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RESPONSES OF FEMALE THERAPISTS TO TREATING
ADULT FEMALE SURVIVORS OF INCEST

by

Marcia A. Hollingsworth

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Counselor Education
and Counseling Psychology

Western Michigan University
Kalamazoo, Michigan
June 1993
RESPONSES OF FEMALE THERAPISTS TO TREATING
ADULT FEMALE SURVIVORS OF INCEST

Marcia A. Hollingsworth, Ed.D.
Western Michigan University, 1993

How female therapists are affected by the long-term experience
of treating adult female incest survivors was addressed by exploring
therapists' commonly reported affective, cognitive, physical, and
imagery responses. The study specifically examined experienced
female therapist responses for evidence of vicarious traumatization
(McCann & Pearlman, 1990b), a transformation process whereby ther-
apists who treat trauma victims may experience profound psychological
effects, including lasting changes in seven basic cognitive schemas.
The study's findings were also considered in relation to four other
models of therapist responses to treating incest survivors: burnout,
secondary post-traumatic stress disorder (PTSD), traumatic counter-
transferences, and countertransference responses.

This study employed a qualitative design, using structured
interviews, to examine the self-reported responses of experienced
female therapists to treating adult female survivors of incest. The
structured interview responses of three female therapists with M.S.W.
training and 10 years experience treating female incest survivors in
outpatient settings were analyzed by a process of internal content
analysis using coding and theme analysis.

The study demonstrated support for McCann and Pearlman's (1990b)
model of vicarious traumatization, in that all the subjects reported negative lasting change in one or more of their cognitive schemas regarding beliefs about themselves in the areas of safety, trust, esteem, intimacy/connectedness, and frame of reference. The findings suggested that female therapists may experience vicarious traumatization in their cognitive schemas having to do with trust/dependence on others, beliefs about the safety of their children, and their frame of reference. Positive lasting changes were also demonstrated by experienced female outpatient therapists in six out of seven cognitive schemas, a finding not anticipated from the current literature.

The study explored the interaction between traumatic content of therapy and the demanding relational processes involved in treating incest survivors. A formulation of therapists' transformational process over time was proposed. Recommendations for female therapists and their supervisors were addressed including ways to offset lasting negative changes in specific schemas, suggestions for education and training, and the importance of a therapist's support system.
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Responses of female therapists to treating adult female survivors of incest

Hollingsworth, Marcia Ann, Ed.D.
Western Michigan University, 1993
ACKNOWLEDGMENTS

I wish to offer my great appreciation to my advisor, Dr. Edward Trembley, for his support, his interest in this study and his thoughtful questions which have strengthened my formulations and analysis. He has offered the balance of a male perspective in what eventually developed into a project influenced by female voices. I also extend my appreciation to the other members of my committee, Dr. Ariel Anderson, for her suggestions and helpful guidance on the method used in this study, and Dr. Suzanne Hedstrom, for her enthusiasm and contributions grounded in her clinical work.

Completing this study has been possible because of the warm support and encouragement of my family. I wish to thank my husband, Kerry, whose life has been a healing journey from other types of childhood trauma. He has provided an interested sounding board for many ideas, as well as computer assistance for my illiteracy. My daughter Stephanie's boundless, optimistic energy for living has been a welcome balance for this project. I also thank my parents, Chuck and Agnes Bult, for their love and support throughout my program.

Finally, I thank the therapists who participated in this study and who so generously shared their knowledge and experience during the interviews. I also acknowledge the courage and creativity of women who have survived incest and use the therapy relationship in their challenging healing journey.

Marcia A. Hollingsworth

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CHAPTER I

INTRODUCTION

In the past two decades, mental health professionals have devoted much attention to the psychological aftermath of traumatic experiences on victims (Figley, 1985; Herman, 1992; Horowitz, 1986; McCann & Pearlman 1990a, 1990b, van der Kolk, 1987), including the effects of catastrophic events (Green, Wilson, & Lindy, 1985; van der Kolk, 1987; Wilson, Smith & Johnson, 1985), of the trauma of war (Wilson, 1988), and violent crime (Terr, 1990). Public and professional awareness of sexual abuse of children, one form of victimization, has also increased tremendously in the last 20 years (Courtois & Watts, 1982; Sgroi, 1988; Wyatt & Powell, 1988). It is difficult to find a daily newspaper which does not contain articles on child sexual abuse. This issue has received increasing attention in mental health literature, addressing signs of abuse (Herman, 1992; Sgroi, 1988; Summit, 1988), sexual abuse as a form of trauma (Briere & Runtz, 1988; Goodwin, 1985; Lindberg & Distad, 1985; McCann & Pearlman, 1990a; McLeer, Deblinger, Atkins, & Foa, 1988), the long-term effects of such trauma on victims (Deblinger, McLeer, Atkins, & Ralphe, 1989; Herman, 1981; McCann & Pearlman, 1990a; Russell, 1986; Shengold, 1989; Watts & Powell, 1988), patterns of child sexual abuse (Briere & Runtz, 1987; Finkelhor, 1984), and treatment modalities for victims and their families (Briere, 1989; Courtois, 1988; Ganzarain &
While there is extensive knowledge about the psychological effects of the trauma of child sexual abuse on its victims, less attention has been given to the enduring psychological consequences for therapists of repeated exposure to the accounts of clients' traumatic experiences. Persons who treat trauma victims may experience powerful psychological effects which pose some risk to the therapist's psychological health (Herman, 1992). Such effects can be both painful and disturbing for the life of the therapist, persisting for months or years after working with traumatized persons (McCann & Pearlman, 1990b).

Statement of the Problem

What are the responses of female therapists to treating adult female survivors of incest, one form of child sexual abuse? How does long-term experience in treating such clients affect female therapists? Many authors (Bernstein, 1989; Bigras, 1990; Briere, 1989; Courtois, 1988; Courtois & Sprei, 1988; Courtois & Watts, 1982; Ganzarain & Buchele, 1986; Gélinas, 1981, 1983; Gil, 1988; Herman, 1981, 1988, 1992; Levine, 1990; Lisman-Pieczanski, 1990, MacCarthy, 1988; McCann & Pearlman, 1990b; Sprei, 1987) have noted that therapy with survivors of childhood incest is difficult work for the therapist as well as the client. Would experienced female outpatient therapists report lasting effects from such work after many years of treating adult female incest survivors?

Incest is defined here as any sexual contact between a child and
person who has blood and/or social ties (i.e., kin) to the subject and her family. Such persons would include father/mother, grandfather/mother, uncles/aunts, siblings, cousins and in-laws, as well as quasi-family, such as parental and family friends (Benward & Densen-Gerber, 1975). The gender of the incest victim and perpetrator may be male or female. A child is understood as a young person under the age of 18. Donaldson and Gardener (1985) have noted that "an incestuous experience is rarely an isolated incident but often occurs over weeks, months, or years" (p. 356). Children keep such abuse a secret for many reasons, including the powerful factor that the people to whom they might report their abuse, namely their parents or family members, are frequently the perpetrators (Gelinas, 1981). Due to the secrecy of the behavior the abuse often goes undetected, and the therapist "may learn of such childhood events only when the adult presents a symptom picture or sometimes after treatment had been long under way" (Donaldson & Gardener, 1985, p. 356).

Some authors have addressed how trauma is contagious, affecting those who serve as a witness to client stories of abuse (Figley, 1985; Herman, 1992). The following models have been developed to account for the responses of therapists who treat trauma victims, including incest trauma: burnout, countertransference, secondary post-traumatic stress, traumatic countertransference, and vicarious traumatization.

The strain of treating a difficult population like incest survivors may result in burnout (McCann & Pearlman, 1990b). Many features of treating this client population are similar to those factors
contributing to burnout with other populations.

Many authors have discussed the responses of therapists in terms of their countertransferences with this population. Some authors (Briere, 1989; Ganzarain & Buchele, 1986; Gelinas, 1981, 1983; Herman, 1981, 1988; MacCarthy, 1988; Sprei, 1987) have identified a range of countertransference responses typical of therapists working with survivors of incest. Other writers (Bigras, 1990; Briere, 1989; Herman, 1981) have noted when treating incest survivors male and female therapists have different gender-related countertransferences which can seriously undermine the therapy. Therapists whose own abuse histories have not been worked through may become overwhelmed with these clients and/or treat the client inappropriately (Briere, 1989; Cole, 1985). Some group therapists (Ganzarain & Buchele, 1986, 1988) have described their experiences of being pulled into specific roles and experiencing confusing countertransferences induced by incest survivors. Psychoanalyst authors (Levine, 1990; MacCarthy, 1988) have noted the powerful impact on analysts in treating incest survivors, identifying countertransference hatred, as well as deadness and despair.

The stresses experienced by therapists treating this client population include the following: isolation (Briere, 1989), repeated exposure to disclosures of victimization (Briere, 1989; Gelinas, 1983), and being the object of client's powerful projective identifications (Catherall, 1991; Levine, 1990; MacCarthy, 1988; Peebles-Kleiger, 1989).

Some writers have suggested that therapists treating trauma
victims, including incest survivors, may experience post-traumatic stress disorder (PTSD) by proxy (Briere, 1989; Herman, 1981) or secondary PTSD (Colrain & Steele, 1992). Herman (1992) has recently suggested that therapists may experience traumatic countertransferences in response to treating survivors and the accounts of the trauma.

Recent work by McCann and Pearlman (1990a & 1990b) has suggested that therapists' fundamental cognitive schemas, or assumptions about self and others, can be altered in lasting ways after working with trauma survivors, including incest victims. They have proposed that therapists who are exposed to the traumatic experiences of trauma victim clients can experience lasting psychological consequences, both painful and disruptive, which can persist for months or years after work with such clients. They have termed this transformation process "vicarious traumatization" (McCann & Pearlman, 1990b, p. 133).

Purpose of the Study

There does not appear to be any formal study of the responses of female therapists who treat adult female incest survivors, and how such treatment of these types of clients might affect the therapist and the therapy. The small, but growing, body of literature on this topic appears to be based on anecdotal observations. Therefore, it is the purpose of this study to explore experienced female therapists' self-reported responses to treating this client population. Using McCann and Pearlman's (1990a & 1990b) model of vicarious
traumatization, this study will examine female therapist responses for evidence of lasting changes in these therapists' cognitive sche-
mas. It will compare the responses of female therapists to the models found in the literature. It will also examine the responses of female therapists for additional variables not yet noted in the literature. It is hoped that this study will contribute to knowledge about the long-term impact on female therapists when treating these clients. This study may provide findings which suggest future stu-
dies of this topic.

In order to facilitate data management in an exploratory inquiry into these issues, this study will limit its inquiry to the response patterns of experienced female therapists who treat adult female incest victims in outpatient therapy settings. For this reason, and to facilitate readability, the feminine pronoun will be used in this study to designate incest victims and their therapists. Although 10% to 20% of reported incest victims are males, female victims continue to comprise 80% to 90% of the known child victims. The symptoms, defenses, transferences, and treatment needs of incest victims which will be discussed in the literature review apply to both male as well as female victims. For a full consideration of the possible spectrum of therapist responses to treating incest survivors, literature addressing the responses of both male and female therapists to treat-
ing this client population has been summarized in the literature review.
Research Questions

The following research questions provide the framework for the proposed research.

1. What are the most commonly reported responses of experienced female outpatient therapists to treating adult female incest survivors?

2. What do experienced female outpatient therapists with over 8 years experience report as being the most demanding aspects of treating adult female incest survivors? (Eight years experience treating incest survivors was chosen as the number of years needed to be an "experienced" therapist, after consultation with members of the doctoral committee and other professionals.)

3. What do experienced female outpatient therapists report as being the most demanding features of therapy when they first began treating adult female incest survivors?

4. What are the differences, if any, in what female outpatient therapists report as being most demanding features of therapy when they first began treating adult female incest survivors compared with their current experience after at least 8 years treating this population?

5. When female outpatient therapists reflect on the impact of treating adult female incest survivors for 8 years or longer, will they report any changes in their cognitive schemas, or their basic beliefs about themselves or others?

6. Do the self-reported responses of experienced female
out-patient therapists to treating adult female incest survivors appear to support McCann and Pearlman's (1990b) model of vicarious traumatization, when treating this population of trauma survivors?

7. When examining the responses of female outpatient therapists to treating adult female incest survivors, are there variables which have not been addressed in the literature which would suggest further study?

Hypotheses

Three hypotheses which follow from the above research questions will be studied in this research:

1. Female therapists with 8 years or more experience treating female adult incest victims will report lasting changes in at least one of their cognitive schemas, for example, their sense of safety, esteem, independence, their sense of trust in others, their sense of power over their life, their sense of being relationally connected, or their belief in a meaningful and predictable world.

2. Female outpatient therapists will report lasting changes in their sense of safety relating to their significant others.

3. Female outpatient therapists will report lasting changes in their sense of intimacy, or being relationally connected with others.

Background

Many authors (Courtois & Watts, 1982; Gelinas, 1981; Summit, 1988) have suggested that despite the prominence this issue seems to receive, only a third to a half of childhood sexual abuse is reported
and treated. This would suggest that perhaps as many as half of such victims may reach adulthood without treatment for the sexual abuse they endured as children. If this is true for child sexual abuse perpetrated in the late 1970s and 1980s, how much more for survivors of child sexual abuse which occurred in the 1940s through the early 1970s when such abuse largely fell outside of public and professional awareness? These were the childhood years of numerous adult survivors of child sexual abuse who are currently presenting symptoms for which they often seek outpatient therapy.

Counselors and therapists who treat adult clients are discovering a large number of such survivors of incest in outpatient settings. Many authors have addressed the high prevalence of sexual abuse and incest (Finkelhor, 1984; Forward & Buck, 1978; Peters, Wyatt, & Finkelhor, 1986). An in-depth interview survey based on a random sample of 930 women in California in the late 1970s indicated that 38% have had a sexual contact before the age of 18 with an adult. Of the 930 women, 16% reported sexual contact with a relative (incest), 4.6% had been involved in father-daughter incest, and only 2% of such abuse was reported to the police (Russell, 1983, 1984).

Two studies cited by Gelinás (1983) from the late 70s reported the prevalence rates of incest among general outpatient caseloads to be as high as 30% and 33%. Gelinás (1983) noted that these reports "are particularly interesting because they suggest the frequency with which outpatient clinicians may be treating undisclosed and unrecognized incest victims" (p. 313). Briere (1989) cited two recent studies (Briere & Runtz, 1987; Briere & Zaidi, 1988) which indicated
that nearly half of the women seeking counseling at an outpatient crisis intervention service and over two-thirds of a psychiatric emergency room sample were sexually abused during childhood.

Many authors (Briere, 1989; Gelinas, 1981, 1983; Russell, 1986) have noted that clients often seek help for problems seemingly unrelated to their sexual abuse, for example, for substance abuse, eating disorders, depression, sexual difficulties, marital discord, or parenting difficulties. Gelinas (1983) found that incest survivors usually seek treatment for the psychological effects or secondary elaborations rather than for the abuse itself.

For many survivors the memories of abuse have been repressed or dissociated, and are largely out of conscious awareness when they first present themselves for therapy. Summit (1988) noted a study which found that 62% of adults in an incest survivors group had earlier forgotten all or most of the childhood abuse. Outpatient therapists may often find that behind a client's presenting symptoms is a history of incest. Such therapists may find themselves treating a significant number of adult incest survivors who are just beginning to deal with the trauma of their experiences.

There is a growing body of literature which has demonstrated that a child's experience of incest is a form of trauma (Courtois, 1988; Gelinas, 1983; Gil, 1988; Herman, 1992). After examining the symptoms of adults who experienced childhood incest, numerous researchers (Briere & Runtz, 1987; Donaldson & Gardener, 1985; Herman, 1988; Lindberg & Distad, 1985; Wilson et al., 1985) suggest that the long-term effects of incest may be a form of post-traumatic stress
disorder (PTSD). "These symptoms include anxiety, recurring nightmares or intrusive daytime imagery, insomnia, depression, anger, guilt, and mistrust. Other long-term self-destructive behavioral patterns include substance abuse, feelings of worthlessness, suicide or suicide attempts, isolation, and/or emotional numbing" (Lindberg & Distad, 1985, p. 329). Numerous authors have suggested that child sexual abuse may produce either chronic or delayed PTSD immediately or in later life (Briere & Runtz, 1988; Deblinger et al., 1989; Donaldson & Gardener, 1985; Gelinas, 1981, 1983; Goodwin, 1985; Kiser, Ackerman, Brown, & Edwards, 1988; Krener, 1985; Lindberg & Distad, 1985; McLeer et al., 1988; van der Kolk, 1987). Herman (1992) has argued that prolonged trauma, like incest, results in a spectrum of conditions rather than a single disorder, which has been termed "complex post-traumatic stress disorder" (p. 119).

Herman (1992) has described the therapy process with trauma survivors, including incest survivors, as turbulent and complex. She has offered an elegant overview of the therapist's difficult task in guiding a client's recovery through three stages: the establishment of safety, remembering and mourning the trauma, and reconnecting with ordinary life.

Significance of the Study

Since it is recognized that outpatient therapists are treating an increasing number of clients disclosing a history of childhood incest, numerous writers have noted that such therapy with survivors of childhood incest is difficult and taxing work for the therapist.
To date, it appears that there have not been any formal studies of the responses of, and impact on, female therapists to treating adult female survivors of incest. There also have not been any studies exploring whether female therapists may experience a process of vicarious traumatization after many years of exposure to the stories of incest trauma resulting in lasting changes in their cognitive schemas. Greater knowledge of responses and possible lasting effects on experienced female therapists would be helpful in many ways. It may offer suggestions for more effective training of therapists in current graduate programs. It may offer suggestions for supervisors of therapists treating this population. The findings may also increase the awareness of current practitioners to common responses and lasting effects of treating this population as well as ways to offset these effects.

A qualitative study of female therapist responses to treating incest survivors is appropriate at this stage of theory building about the impact of such work. A focused exploration and analysis of female therapists' experiences may yield additional knowledge about their response processes. Such a study may provide background information for planning future psychological studies. It may test the adequacy of current conceptualizations and may reveal important variables that warrant further attention, as well as provide results for theory building. It is the intention of this study to investigate and describe the self-reported response patterns of experienced female outpatient therapists in the treatment of adult female survivors of incest. It is hoped that the findings of this research may
suggest answers to some of the previous research questions. It is hoped that this research will have educational value for therapists and their supervisors who provide outpatient treatment for adult survivors of incest.

Definitions of Terms

Definitions of terms used in this study follow:

Countertransference: Countertransference refers to the therapist's total response to the client in the therapeutic interaction, including all thoughts and feelings, both conscious and unconscious (Tansey & Burke, 1989).

Dissociation: Dissociation, a defense mechanism, is an alteration of consciousness in which experiences and affect are not integrated in memory and awareness. It is a cognitive disturbance often experienced by trauma victims (McCann & Pearlman, 1990a).

Incest: Incest refers to sexual contact with a person who have blood and/or social ties (i.e., kin) to the subject and her family. Such persons would include father, mother, stepfather/mother, grandfather/mother, uncles/aunts, siblings, cousins, in-laws, and parental and family friends (Benward & Densen-Gerber, 1975).

Lasting changes in fundamental cognitive schemas: Lasting changes (also enduring changes) are therapist self-reported alterations persisting for a year or more after the experiences producing the change. McCann and Pearlman (1990b) define lasting changes as those which persist for months or years. Fundamental cognitive schemas are cognitive representations of basic human needs. The
seven fundamental cognitive schemas identified by McCann and Pearlm an (1990a & 1990b) are frame of reference, safety, dependency/trust, power, esteem, intimacy and independence. Evidence of such lasting changes in a therapist's fundamental cognitive schemas could be found in the self-report of a therapist's experience of herself, her significant others, and her clients.

**Outpatient therapy setting:** An outpatient therapy setting is one in which psychotherapy is provided to clients who reside elsewhere. Such psychotherapy is typically pre-scheduled, with a specific time and frequency frame (e.g., a 50-minute session, once a week). The personnel do not have responsibility for the management of client's care for the client's life outside the setting.

**Repression:** Repression is an unconscious defense mechanism "that banishes unacceptable ideas, fantasies, affects or impulses from consciousness or that keeps out of consciousness what has never been conscious" (American Psychiatric Association, 1980, p. 119).

**Survivor:** In this study, survivor is an adult who was incestuously abused as a child and one who is no longer enduring such abuse.

**Therapy:** (Also psychotherapy) Psychotherapy is a "process in which a person who wishes to relieve symptoms or resolve problems in living or is seeking personal growth enters into an implicit or explicit contract to interact in a prescribed way with a psychotherapist" (American Psychiatric Association, 1980, p. 116).

**Therapist:** A person with a master's or doctoral level training to provide psychotherapy. Such training would include programs

**Trauma:** A trauma is an experience (or series of experiences) which "(1) is sudden, unexpected, or non-normative, (2) exceeds the individual's perceived ability to meet its demands, and (3) disrupts the individual's frame of reference and other central psychological needs and related schemas" (McCann & Pearlman, 1990a, p. 10).

**Vicarious traumatization:** Vicarious traumatization is a process whereby individuals who treat trauma survivors, including incest trauma, may experience profound psychological effects which may persist for months or years. Psychological effects may include lasting changes in treaters' cognitive schemas (McCann & Pearlman, 1990b).

**Victim:** A victim is one who has suffered from some form of abuse through no fault of her own and who has been made to suffer by persons beyond her control. In this study, the term "victim" will be used when referring to the condition of the child during the time of the actual abuse.
CHAPTER II

REVIEW OF RELATED LITERATURE

Commonly Reported Therapist Stressors

Many writers have addressed the stresses on the therapist in treating incest victims. For comparison, it is worth noting that many researchers (Deutsch, 1984; Farber, 1983; Guy, 1987; Hellman, Morrison, & Abramowitz, 1986; Jaffe, 1986; Kottler, 1986) have noted a number of stresses commonly found in the personal and professional life of psychotherapists, without reference to a specific client population. A commonly reported stressor for therapists is the isolation in the work (Guy, 1987; Kottler, 1986; Tryon, 1983). Some of the factors which Guy (1987) has noted which contribute to this isolation are the following: (a) isolation from a balanced range of human behaviors and emotions in favor of client's concerns, (b) setting aside the therapist's personal needs and concerns in favor of the client's needs, (c) modulating their emotional responses for the benefit of the client, and (d) the one-way intimacy of the therapy relationship. Therapists have reported (Deutsch, 1984; Farber, 1983; Hellman et al., 1986) the following client behaviors to be the most stressful: suicidal ideation, aggression and hostility toward the therapist, severely depressed clients, apathy and lack of motivation, and premature termination. All of these behaviors are characteristic
of adult survivors of incest as well as clients without an incest history.

**Additional Stressors on Therapists Treating Incest Survivors**

Successful treatment of adult survivors of incest is often complicated by the long-term secrecy and shame of such experience, as well as the commonly used defenses of repression and/or dissociation of incest memories. Such memories are often repressed or dissociated for decades. Herman (1988) discussed the powerful impact on therapists when she points out that such client disclosure,

is entirely dependent on the clinician's willingness to hear, respect and validate the patient's experiences and to bear, with the patient, all the associated affect. With increasing tolerance, the clinician can expect to hear an increasing number of histories that include atrocities. The limits of the clinician's own affect tolerance are constantly challenged. For this reason, the clinician who works with victims must be assured of dependable access to supportive peers in order to cope with the contagion of post-traumatic stress disorder that affects caregivers. (p. 191)

Shengold (1979, 1989) maintained that clients who have experienced chronic child abuse and deprivation, including incest, have experienced "soul murder." The therapist has the difficult task of suspending disbelief when hearing the client's stories of cruelty and incest. He noted that the therapist's most difficult job is dealing with the client's powerful transference and projection.

**Current Models: Effects on the Therapist in Treating Incest Survivors**

Current conceptualizations of the incest trauma survivor's
impact on the therapist and psychotherapeutic process will be reviewed, including burnout, countertransference, secondary post-traumatic stress disorder, traumatic countertransference, and vicarious traumatization.

**Burnout**

Burnout generally refers to the psychological strain of working with difficult populations over time and/or where one's work expectations are chronically frustrated. The symptoms of burnout include depression, cynicism, boredom, loss of compassion, and discouragement (Freudenberg & Robbins, 1979). McCann and Pearlman (1990b) reviewed the research on burnout among therapists finding the following contributing factors:

- professional isolation, the emotional drain of always being empathetic, ambiguous successes (Bermak, 1977); lack of therapeutic success, non-reciprocated giving and attentiveness (Farber and Heifetz, 1982); and failure to live up to one's own (perhaps unrealistic) expectations, leading to feelings of inadequacy or incompetence (Deutsch, 1984).

Although the burnout literature has not focused on the experience of treating trauma survivors in general, or survivors of incest trauma specifically, this concept may be relevant to treating this population. McCann and Pearlman (1990b) have further maintained that while the burnout literature is relevant, "the potential effects of working with trauma survivors are distinct from those of working with other difficult populations because the therapist is exposed to the emotionally shocking images of horror and suffering that are characteristic of serious trauma" (p. 134).
Countertransference

The burnout literature places the focus on the characteristics of the stressor, suggesting that the therapist is distressed by the nature of the external event; for example, treating a difficult client population or the isolation of the therapist. In contrast, much countertransference literature often focuses on the personal characteristics of the therapist, with countertransference being prompted by the therapist's prior relational history and previously unresolved psychological conflicts. Treating symptomatic clients with powerfully abusive histories prompts a range of countertransference responses in therapists. Before reviewing the literature on countertransferences to such clients, the nature of countertransference will be considered.

Definitions and Components of Countertransference

Early classical formulations (Freud, 1900/1957; Reich, 1951, 1960) held that countertransference was comprised of the effects of the analyst's own unconscious needs and conflicts on one's technique or understanding of the client, that it adversely affected treatment and should be overcome. Numerous theorists (Epstein & Feiner, 1979; Heinmann, 1950; Langs, 1979; Little, 1951, 1957; Racker, 1968; Sandler, 1976; Winnicott, 1949) have challenged this position with a broader view of countertransference as a useful tool. From a relational/structural model of psychoanalysis, Peebles-Kleiger (1989) has stated:
Countertransference is no longer the warp in the screen; in some ways it is the screen itself. Feelings toward the patient that influence the observational perspective, and sometimes the work itself, are no longer by-products of unresolved conflicts in the therapist. Such feelings are instead inevitable aspects of the interaction. More than that, they provide crucial clues to understanding the patient's past. Thus, in this model, countertransference shifts from impeding to facilitating treatment. (pp. 520-521)

Current object relations theorists (Cashdan, 1988; Hamilton, 1988; Tansey & Burke, 1989) have defined countertransference as the therapist's total emotional and cognitive response to the client. They have developed a conceptual model of countertransference using the concepts of projective identification, introjective identification and empathy to identify aspects of the therapist's relational process with a client and how these processes can be used to enhance treatment. Tansey and Burke (1989) have defined projective identification as "an interactional phenomenon in which the projector, by actual influence, unconsciously elicits thoughts, feelings and experiences within another individual which in some way resemble his own" (p. 45). When a client's projective identification has been successful there is a corresponding introjective identification within the therapist. Tansey and Burke (1989) have suggested that introjective identification is the phenomenon of the therapist intrapsychically taking in the client's projected material, identifying with the introject in the presence of the client who is exerting the interactional pressure of projective identification. A therapist's internal experience is always a combination of her own tendencies and the type of relationship the client is trying to enact, often
influenced by the client's projective identifications. These authors maintained that therapist empathy can result from processing a client's projective identification successfully, leading to an emotional knowledge of the client's experience.

Current psychoanalytic theorists (Aron, 1992a, 1992b; Hirsch, 1992) have explored transference and countertransference as a "two person psychology" (Hirsch, 1992, p. 197). One implication of their "relational-perspectivist" view is that aspects of the therapy involve complex intersubjective processes conjointly between client and therapist. The client and therapist participate in a relationship involving "mutual influence and mutual reading of one another" (Hirsch, 1992, p. 201). This may have implications for understanding how experienced female therapists are affected by their incest survivor clients.

**Countertransference With Incest Survivors**

There is a growing body of literature addressing therapist countertransference with survivors of incest. Researchers and clinicians addressing treatment issues related to incest survivors have discussed some of the effects this work has on therapists, particularly focusing on countertransference.

have discussed the challenges and potential difficulties for the therapist treating adult survivors of incest. Gelinas (1983) stressed that since incest is a relationally-based injury involving betrayal of trust, abandonment and exploitation by a family member, persons with this history tend to induce future relationships to follow the same patterns. Lisman-Pieczanski (1990) stated that therapists face the challenge of

helping people whose inner world is populated by parental imagoes linked with neglect, violence, and disregard for their helping people whose inner world is populated by parental images [inner representations] linked with neglect, violence and disregard for their infantile needs. The result of such disordered internal object relationships is a constant, unconscious pressure to turn the analysis into a sadomasochistic experience. Contact with these patients deeply affects the therapist's inner balance and capacity to understand and care. (p. 145)

Briere (1989) maintained that such transferenceentially-based survivor dynamics demand great effort and clarity from the therapist. He stated that the therapist

not only must correctly respond to evocative and/or challenging behavior, but also must keep from reacting on a personal level, despite the potential for survivor dynamics to bring to the fore the therapist's own childhood issues or socially learned biases. (p. 73)

Briere (1989) identified two major sources of negative therapist countertransference to abuse-focused psychotherapy: issues related to therapist gender socialization and the therapist's own childhood experience of abuse. He used a narrower view of countertransference as "biased therapist behaviors that are based on earlier life expectations or learning" (p. 73). Although he did not define "negative" countertransference, it would seem he meant those
countertransferences with a negative bias arising out of the therapist's earlier relational experiences.

**Gender-related Countertransference With Sexual Abuse Survivors.**

Some authors (Bigras, 1990; Briere, 1989; Courtois, 1988; Cole, 1985; Herman, 1981) have noted that therapist reactions to sexual abuse survivors may be influenced by the therapist's gender, due in large part to the contrasting socialization of males and females. Both males and females are influenced by sex-role stereotypes of North American society which influences subsequent interpersonal perceptions and expectations. Briere (1989) stated that "Males in our culture . . . are socialized to view most emotionally intimate relationships as potentially sexual ones (Finkelhor, 1984), resulting in a tendency to respond to certain essentially non-sexual interactions as if they were sexual in nature" (cited in Briere, 1989, pp. 75-76).

Since not all male therapists have unlearned this "false equation" (Briere, 1989, p. 76), some have a tendency to sexualize their female clients. When working with female incest survivors who often respond to male power submissively or with pseudo sexual behaviors, this male sexualization dynamic may be intensified, with the possible revictimization of the client during treatment.

Bigras (1990), a psychoanalyst, reported that many of the incest survivors in his practice reported being severely traumatized in prior therapy with male therapists who had sexually abused them or who treated them with a cool, detached therapeutic stance. From his supervisory experience, he has observed that in response to seductive
behavior of female clients, male therapists may be overwhelmed or have more difficulty dealing with the "profound oral deprivation of these patients" (p. 194). He added that male therapists have difficulty "finding a way to be kind without being overprotective, present without being intrusive, available without being aloof" (p. 194).

Although not as prone to such sexualization or sexual acting out, female therapists are subject to substantial gender effects. Overidentification with the incest survivor is probably the most frequent female response (Bigras, 1990; Briere, 1989; Courtois, 1988; Herman, 1981). Based on her own experience with male aggression, sexualization, or fears of aggression and victimization, female therapists may closely identify with the client's experience of victimization. Bigras (1990) noted that the female analyst's difficulties can be linked "to massive sadomasochistic maternal transference" (p. 195) of adult incest survivors. The therapist may respond with two overidentification patterns (Briere, 1989; Bigras, 1990). One may be with overinvolvement, possibly characterized by agitated concern and extreme nurturance. As a defensive counterpart, the second pattern is one of denial and underinvolvement, motivated by the therapist's need to keep the pain, and/or fear of victimization out of awareness, thus maintaining a sense of safety. The therapist may deny that the abuse took place or doubt its negative impact.

Therapist's Abuse History and Countertransference. Based on the prevalence data reported earlier, Briere (1989) has suggested that at
least one-third of female therapists and 10-15% of male therapists have sexual abuse histories. He also suggested that much larger percentages have experienced physical and/or emotional childhood abuse.

The impact of a therapist's abuse history on working with survivors depends on therapist and situation variables. Briere (1989) suggested that if a therapist's abuse has been worked through, with responses being integrated and conscious, the abuse experience can be an asset, providing an understanding of client dynamics. However, he has suggested that therapists "who are still at odds with their abuse, who use denial, dissociation, or splitting to deal with abuse-related dysphoria, are likely to discover that working with other people's victimization issues restimulates their own" (Briere, 1989, p. 74), increasing such problems as PTSD symptoms and under or over-investment in the client (also see Cole, 1985). Further, he suggested that such therapists may use projection of their own issues onto their clients. They may also use denial or avoidance, unconsciously working to prevent clients from exploring their own memories. A third outcome from a therapist's unconscious abuse history may be that the therapist becomes overwhelmed with the client's needs and issues. Therapy may become chaotic, boundaries may become confused, and/or roles reversed, with the client caring for the therapist.

Other Sources of Countertransference. Briere (1989) discussed a number of additional pitfalls associated with the difficult
therapeutic work with sexual abuse survivors. Although he does not consider these as countertransferences in his narrow definition, they would be included in the broader definition of countertransference used in this study. Clinicians are prone to feelings of isolation for a number of reasons specific to treating trauma survivors. First, it is difficult to share the experience of listening to a client's horrendous experiences, even with other clinicians. Fellow clinicians may subtly discount incest trauma work, prompting some therapists to withdraw from standard resources and support systems when needed most. Briere (1989) stated, "psychotherapy with victims is a relatively autistic process, a closed system where the therapist absorbs the client's pain and often is unable to fully unburden it to others" (p. 168). Another dimension of this isolation stems from a society that discounts abuse and its effects, will also discount clinicians who do this work and the veracity of their clients.

Amplifying on the therapist's sense of isolation, Levine (1990) described a particular countertransference problem not often appreciated in psychoanalysis of adult survivors of child sexual abuse. He underscored the analyst's feelings of "boredom, affective deadness, confusion, intense isolation, despair and unrelatedness" (p. 214), all countertransference responses to the client's need to avoid dependency and intimacy due to fears of repeating the childhood trauma. He suggested that the analyst should be prepared for long, ungratifying periods of affective deadness in therapy until the client's affective withdrawal can be understood and worked through.

Another important therapist pitfall is the impact of the actual
content of therapy. Briere (1989) stated:

Therapeutic work with former sexual abuse victims routinely involves dealing with violence and cruelty at a level that most people would find incomprehensible. Repeated exposure to disclosures of victimization, exploitation, and resultant self-destructiveness and rage can slowly produce a PTSD by proxy in the listener. (p. 169)

Gelinas (1983) also said that dealing with painful abuse stories and after-effects on the client can test both the therapist's abilities to handle such material and conviction that this is an essential path for the client's healing.

Like Gelinas, Bernstein (1989) noted that the recognition of incest is largely determined by the therapist's willingness to recognize it. She reported that in 1985 the American Psychoanalytic Association held its first panel to compare case material relating to adults sexually abused as children. This panel mentioned two "countertransference pitfalls" pertaining to such clients, which are not often found with clients who have only "fantasies of seduction" (Bernstein, 1989, p. 208). Bernstein (1989) reported that these pitfalls involve

- the tendency first to deny the reality of the patient's experience and later to get caught up in the frightening aspects of the reality endured by the patient. The contagion of panic and the wish to stop the painful abreaction, as it inevitably occurs in a proper psychoanalytic situation, is a common experience. (p. 209)

Briere (1989) noted the following effects on clinicians when treating survivors of sexual abuse: an increase in violent or distressing dreams; hypervigilence to personal danger; increased irritability and anxiety; decreased ability to appropriately deal with stress; increased difficulties in personal relationships; and a
general sense of helplessness; sometimes resulting in cynicism or chronic anger at the system. Abuse related material can also slowly damage a clinician's perspective regarding survivors, resulting in either over- or underinvestment in one's clients. Here he does not link the responses of over- or underinvestment to therapist gender. As a form of dissociation from the client's trauma, underinvestment may take the form of being numb to what would typically evoke anxiety, anger, or other intense feelings. Such therapists may have a detached professional manner, have a need for psychological distance from their client's pain, and seek to understand the client as one who caused or deserved her history. Briere (1989) noted that forms of overinvestment with clients include the therapist taking parental or rescuing roles inside and outside the therapy hour, seeing the client many times a week, failing to confront destructive behavior, or pushing clients into particular affective states held by the therapist, e.g., extreme anger at parents or perpetrator.

Some writers describe countertransference responses based on working with incest survivors in group therapy. Since group therapy is significantly different from individual therapy, the following response patterns may not correspond to those experienced by therapists working with clients in individual treatment. However, the countertransference responses experienced in group therapy will be summarized for comparison.

Sprei (1987) suggested that in response to painful subject matter shared by incest survivors in group treatment, therapists may be overwhelmed and use defenses similar to those of incest survivors.
She identified the following four defense categories:

1. **Avoidance/minimization**: The therapist may avoid the incest experience by discouraging exploration of the trauma, overgeneralizing how everyone is somehow victimized, avoiding terms like incest and violation, or by maintaining an overprofessional, distant stance.

2. **Overprotection/rescuing**: The therapist may treat the survivor as overly fragile, or very special, without acknowledging her strengths.

3. **Therapist anger and rage**: Expression of therapist anger or rage can cause problems if expressed too early in the therapy relationship or too intensely for the client. The client can find mistimed or intense therapist anger overwhelming. Also, mistimed expression of therapist anger may hinder the client expressing ambivalent or positive feelings for the perpetrator.

4. **Voyeurism**: Therapist shock, fascination, and excessive interest in the sexual details of incest, without attention to the aftereffects, can prompt the client to feel revictimized.

Also based on their experiences in group therapy, Ganzarain and Buchele (1986, 1988) have noted the paucity of literature on the issue of countertransference when treating adults who have been sexually abused as children by family members. They have contributed a summary of the range of countertransferences they experienced as cotherapists (one female, the other male), and how they used their emotional response to understand and treat their clients in a group setting.

These therapists described a variety of transference patterns
and social attitudes acted out as roles by clients through projective identification, inducing countertransferenceal "role suction and/role reversals" (Ganzarain & Buchele, 1986, p. 552). These clinicians described multiple, contradictory family and societal roles incest victims learn during childhood. The following is a summary of some of the roles they observed and experienced in group therapy. Some incest survivors acted out the role of "favorite one in the family" (Ganzarain & Buchele, 1986, p. 552) and later shifted to its opposite, the role of victim. Such shifts were very confusing for the therapists, and difficult, because the clients often put pressure on the therapists to assume complementary roles, such as the role of aggressor to the client's role of victim. Another pair of childhood roles acted out by their clients were those of "rival" to either their mother or father, versus a "dependent small child" (Ganzarain & Buchele, 1986, p. 553) still needing protection and nurturing. Other roles enacted by survivors were that of a "child versus parent;" "victim versus victimizer;" "perverts and normal individuals" (Ganzarain & Buchele, 1986, p. 553); "sexual experts and shameful ignorance" (Ganzarain & Buchele, 1986, p. 553); "victims of forceful seduction and powerful aggressors" (Ganzarain & Buchele, 1986, p. 554); "special at home (or in court!) and an 'outcast' with peers" (Ganzarain & Buchele, 1986, p. 555); "chronic liars versus honest informers" (Ganzarain & Buchele, 1986, p. 555). They noted that clients with a history of incest abuse enact a variety of such roles in treatment, sometimes acting the role of victim, at other times identifying with the aggressor. The fluctuation of roles can cause
confusion in the therapist. Ganzarain and Buchele (1986) noted that such clients "elicit in the treaters the complementary opposite roles, exercising on them a role suction (Redl, 1963), putting pressure on them through projective identification. Treaters can be pushed into assuming some of these roles" (cited in Ganzarain & Buchele, 1986, p. 556).

Ganzarain and Buchele (1986) described the following countertransference responses as group therapists: revulsion, disbelief and/or minimization of the abuse; rescue fantasies; sexual fantasies across gender; guilt and anxiety; sadness; anger at offenders; confusion about where to place love and loyalty; frustration about the slow work on complex problems; mistrust and fear about being at the mercy of client's sadistic urges; betrayal; and devaluation. They noted that "it took considerable effort to sort out what these patients elicited in us" (p. 565). At times they felt deskillled by the powerful, intense countertransference responses elicited by such clients with the emotional scars of incest.

Peebles-Kleiger (1989) described the usefulness of the relational/structural model of countertransference in the treatment of trauma victims. She drew all of her examples from the therapeutic treatment of victims of incest trauma. Both Peebles-Kleiger (1989) and Cathcart (1991) noted that therapists of trauma victims are vulnerable to split-off projections from their clients via projective identification.

Victims of trauma often manage the overwhelming onslaught of affect by dissociating from and then splitting off certain aspects of the traumatic experience. These
split-off aspects are unmetabolized and unintegrated into the person's self-experience, so they exist as unstable particles in the patient's internal world and are ripe for projection into the outer world onto the other. . . . in trauma victims, primitively dissociated and split-off aspects of the trauma experience are typically projected into the outer world via the mechanism of "projective identification." . . . Such projective identification creates special countertransference problems for therapists. (Peebles-Kleiger, 1989, p. 519)

Both Peebles-Kleiger (1989) and Catherall (1991) have suggested that intense countertransference affects, like aggression, may reflect feelings the client cannot verbalize. Such countertransferences can be used diagnostically and to form an empathic connection with the client.

According to Peebles-Kleiger:

For a countertransference experience to be diagnostic, the therapist first allows the full depth of feelings, without dissociating or otherwise defending against the experience. Then a disciplined subjectivity, . . . helps the therapist differentiate feelings originating in the patient from feelings originating in himself or herself. Finally, if the felt experience originates in the patient, therapists try to determine whether it reflects an aspect of something the patient felt . . . or an aspect of something the patient experienced as coming from someone else in the early environment. (1989, p. 523)

According to Catherall:

The therapist who is open to experiencing an empathetic connection via resurrection of his or her own aggression and disowned identity fragments conveys a message of confidence in the patient's capacity to endure these feelings without acting out dangerously. (1991, p. 148)

Catherall (1991) also noted the following as an alternate therapist response:

The therapist who must rigidly defend against the reinstatement of his or her disowned identity fragments will have difficulty accepting the projective identification and maintaining an empathic bond. Such therapists will be
likely to distance from the patient--perhaps through means such as labeling the person--and the therapist will disown any common experience with the patient. (p. 147)

Finally, both authors have explored how the clients can more effectively integrate formerly split-off affects as the therapist handles the client's projective identifications and resulting countertransferences constructively. The process they described is similar to the processing of projective identifications to gain empathic knowledge of the client's experience noted earlier by Tansey and Burke (1989).

Countertransference Hate. MacCarthy (1988), a British analyst, asked the provocative question, "Are incest victims hated?" (p. 113) by their families, by society and eventually by their therapists. He believed that based on prior family abuse and neglect, the victim usually concludes that disclosure will elicit a hostile environmental response, including disbelief, blame, indifference or outright hostility. He suggested that incest victims often demonstrate powerful feelings of hate, which may be directed at the offender, or the mother who did not protect them. This hate may include child-protection agencies which failed to protect, as well as professions which provide counseling or therapy. This hatred and expectations of being hated surfaces in therapy and offers a serious treatment challenge.

Writing from a psychoanalytic perspective, MacCarthy (1988) stated:

The slightest lapses in technique, any hint of muddle or confusion in the analyst, often precipitate an abrupt loss of confidence and outbursts of hate. Part of the stress of this work is the patient's facility to rid herself of confusion by projecting it into the analyst who may then exhibit signs of confusion himself. These patients search
relentlessly for evidence of confusion or weakness in the analyst. (pp. 116-117)

MacCarthy wrote from the experience of treating incest survivors in long-term psychoanalysis which can be a more intense, in-depth experience than weekly out-patient therapy. One wonders whether he may have noted some of the deeper effects of working with incest survivors, effects which typically may be out of therapist awareness or otherwise well-defended. His findings may serve as a guide for therapists working with incest survivors in longer-term outpatient therapy.

MacCarthy (1988) maintained that in spite of our "enlightened times" incest victims are often feared and hated by social service departments and even treatment professionals. He reflected on is own 15-year intensive treatment experience with incest victims and that of Alvin Rosenfeld (1987), an American expert on the treatment of incest victims. Rosenfeld suddenly gave up this work after 10 to 12 years, feeling that working with incest victims induced a form of burnout. MacCarthy noted that he has not had an incest victim in intensive treatment since 1986. He believed that "there is no more potent expression of hate than to turn your back, to walk away" (p. 199). He asked "Why, when I have reached a reasonable level of competence with incest victims, do I decide to abandon them, to turn a blind eye . . .?" (p. 199). He concluded:

I feel it may be my expression of unconscious hate, or that pervasive and leaden sense of inner desolation I feel so often, a desolation which mirrors faithfully the inner desolation so well known to these patients . . . . But I know I would have to overcome a considerable obstacle within myself before I would agree to start another
intensive analysis with a new incest case. (p. 120)

Current Models: Effects on Therapists
Treating Trauma Victims

Models Addressing Effects on Trauma Survivors

A brief discussion of post-traumatic stress disorder (PTSD) and complex PTSD, two models which account for the effects of trauma on survivors, including incest trauma, are offered as background for understanding traumatic countertransference, secondary PTSD and vicarious traumatization, recent formulations accounting for therapist responses to treating trauma survivors like incest survivors.

Post-Traumatic Stress Disorder

In the last decade, the most frequently cited model to explain the immediate and long-term effects of sexual abuse has been the post-traumatic stress disorder (PTSD) model. Numerous authors have suggested that child sexual abuse may produce either chronic or delayed PTSD immediately or in later life (Briere & Runtz, 1988; Deblinger et al., 1989; Donaldson & Gardener, 1985; Gelinas, 1981, 1983; Goodwin, 1985; Kiser et al., 1988; Krener, 1985; Lindberg & Distad, 1985; McLeer, 1988; van der Kolk, 1987). PTSD has been defined by the DSM III R (American Psychiatric Association, 1987) as including the following features:

1. The existence of recognizable stressor that would evoke significant symptoms of distress in almost anyone.

2. The re-experiencing of the trauma either through (a)
recurrent intrusive recollections, (b) dreams, or (c) sudden feelings.

3. A numbing of responsiveness or reduced involvement in the external world indicated by diminished interest in activities, feelings of estrangement from others, constricted affect, or dissociation.

4. In addition, at least two of the following set of symptoms need also be present: hypervigilance, sleep problems, irritability, problems with memory or concentration, avoidance of activities, or the intensification of symptoms when exposed to stimuli related to the traumatic event.

PTSD theory also proposes that the traumatic symptoms following child sexual abuse are not pathological in themselves. Rather, they develop as natural coping responses to unusual catastrophic events. In some persons such symptoms fade quickly; in others, they continue and become chronic; others may develop delayed symptoms. Building on the work of Horowitz (1986), Brett and Ostroff (1985) suggested that the symptoms of PTSD can be organized in a two-dimensional framework of (a) a repetition phenomena including intrusive images, dreams, dissociative episodes including flashbacks, and re-enactments; and (b) defense which includes emotional numbing, suppression and avoidance of memories, and psychogenic amnesia. Donaldson and Gardner (1985) have noted that incest survivors who exhibit the symptoms of PTSD often report a history of such cyclical alternating between denial or numbing and intrusive-repetitious thoughts.
Complex Post-traumatic Stress Disorder

Herman (1992) has recently argued that the diagnosis of PTSD does not provide an accurate fit for survivors of "prolonged, repeated trauma" (p. 119) like incest because the symptom picture is more complex with "profound deformations of personality" (p. 119) which occur from prolonged childhood abuse. She maintained that the diagnostic criteria of PTSD have been "derived mainly from survivors of circumscribed traumatic events" (p. 119), like combat, disasters and rape. She has proposed that the responses to prolonged trauma under conditions of captivity can be better understood as a spectrum of conditions rather than a single disorder, which is being termed "complex post-traumatic stress disorder" (p. 120). Complex post-traumatic stress disorder is being considered for inclusion in the fourth edition of the diagnostic manual of the American Psychiatric Association based on the following seven diagnostic criteria:

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples include... prisoners of war, concentration-camp survivors. ... Examples also include those subjected to totalitarian systems in sexual and domestic life, including ... childhood physical or sexual abuse.

2. Alterations in affect regulation, including: persistent dysphoria, chronic suicidal preoccupation, self-injury, explosive or extremely inhibited anger (may alternate), compulsive or extremely inhibited sexuality (may alternate).

3. Alterations in consciousness, including: amnesia or hypermnnesia for traumatic events; transient dissociative episodes; depersonalization/derealization; reliving experiences either in the form of intrusive post-traumatic stress disorder symptoms in the form of ruminative preoccupation.

4. Alterations in self-perceptions, including: sense
of helplessness or paralysis of initiative; shame, guilt, and self-blame; sense of defilement or stigma; sense of complete difference from others (may include sense of specialness, utteraloneness, belief no other person can understand, or nonhuman identity).

5. Alterations in perception of perpetrator, including: preoccupation with relationship with perpetrator (includes preoccupation with revenge); unrealistic attribution of total power to perpetrator (caution: victims' assessment of power realities may be more realistic than clinician's); idealization or paradoxical gratitude; sense of special or supernatural relationship; acceptance of belief system or rationalizations of perpetrator.

6. Alterations in relations with others, including: isolation and withdrawal; disruption in intimate relationships; repeated search for rescuer (may alternate with isolation and withdrawal); persistent destruct; repeated failures of self-protection.

7. Alterations in systems of meaning: loss of sustaining faith; sense of hopelessness and despair. (Herman, 1992, p. 121)

Herman (1992) stated that survivors of childhood abuse, in which she included incest, are often given a variety of pejorative diagnoses including somatization disorder, borderline personality disorder, and multiple personality disorder (MPD) before the underlying conditions of complex post-traumatic stress disorder are recognized.

The following recent models addressing the impact on therapists who treat trauma victims, including incest, will be discussed: secondary post-traumatic stress disorder, traumatic countertransference, and finally, vicarious traumatization.

Secondary Post-traumatic Stress Disorder

Several writers have proposed that therapists treating trauma survivors, including incest survivors, may experience post-traumatic
stress disorder (PTSD) by proxy (Briere, 1989; Herman, 1981) or secondary PTSD (Colrain & Steele, 1992). Briere (1989) has not elaborated on what form PTSD by proxy would manifest itself in therapists working with survivors of sexual abuse. Colrain and Steele (1992) have suggested that secondary post-traumatic stress disorder in therapists working with survivors of sexual abuse may take the following forms. Many of these correspond or seem to be responses to the symptoms of PTSD listed earlier:

1. Intrusion phenomenon which include intrusive images or thoughts about the content of therapy.

2. Numbing phenomenon including boredom, sleepiness or preoccupation in the therapy hour.

3. Mild to moderate dissociative symptoms including forgetfulness, blanking out, spaciness; increasing difficulties maintaining limits and boundaries with survivor clients.

4. Preoccupation with evil and abuse in the world.

5. Feeling unsafe and untrusting even of colleagues.

6. Increasing isolation from family, friends, and colleagues who don't understand.

7. The content of therapy is the primary topic of conversation or the inability to talk about the content at all.

8. Lack of energy around any tasks besides those related to abuse issues; emotional and physical fatigue.

9. Intense spiritual anguish and existential crises.

10. A sense of desperation, helplessness or hopelessness.

11. Feeling overwhelmed or incompetent; Increased frequency of
physical illness and days missed from work.

12. Depression, anxiety; sleep disturbances and nightmares.
15. Anhedonia.
16. Excessive focus on identification and prosecution of perpetrators as a focus of therapy.

Traumatic Countertransference

Herman (1992) has suggested that clients who suffer a traumatic syndrome form traumatic transferences in the therapy relationship. She stated:

Their emotional responses to any person in a position of authority have been deformed by the experience of terror. For this reason, traumatic transference reactions have an intense, life-or-death quality unparalleled in ordinary therapeutic experience. . . . The psychiatrist Eric Lister remarks that the transference in traumatized patients does not reflect a simple dyadic relationship, but rather a triad: "The terror is as though the patient and therapist convene in the presence of yet another person. The third image is the victimizer, who . . . demanded silence and whose command is now being broken." (Herman, 1992, pp. 136-137)

Herman (1992) has suggested that the therapist may experience traumatic countertransference which "includes the entire range of therapist's emotional reactions to the survivor and to the traumatic event itself" (p. 141). It appears that her concept of traumatic countertransference includes the symptoms of secondary post-traumatic stress disorder and the process of vicarious traumatization, which will be discussed next. She maintained that the therapist has to
grapple with the same "disruptions in relationship" (Herman, 1992, p. 141) as the client. She has discussed the following traumatic countertransferences, many of which seem to be responses related to the symptoms listed earlier in complex PTSD:

1. Experiencing helplessness, causing one to underestimate her knowledge and skill.
2. Feeling suddenly incompetent and hopeless.
3. Assuming the role of rescuer as a defense against helplessness, with possible violation of the bounds of therapy.
4. Assuming a stance of grandiose specialness or omnipotence as another extreme defense against helplessness.
5. Identifying with the victim's rage and mishandling this in many ways.
6. Experiencing profound grief and succumbing to despair.
7. Identifying with the feelings of the perpetrator by any of the following: being skeptical of the client's story, minimizing the abuse, or feeling judgmental when the client fails to perform according to some idealized view of the "good" victim, feeling contempt for the client's helplessness, paranoid fear of the client's rage, or frankly hating the client; voyeuristic excitement, fascination, and even sexual arousal.
8. In the role of unharmed bystander, experiencing "witness guilt."
9. "Existential panic" (Herman, 1992, p. 140) with bizarre images or dreams and uncharacteristic dissociative experiences, including numbing, depersonalization, derealization, and passive
influence experiences (Herman, 1992, pp. 140-147).

Vicarious Traumatization

McCann and Pearlman (1990a, 1990b) have suggested that long-term exposure to the traumatic experiences of trauma victims may alter therapists' cognitive schemas, namely their beliefs, expectations, and assumptions about self and others. Such schema are cognitive representations of basic psychological needs. When they address the experience of treating trauma survivors, they included not only incest survivors but also Vietnam veterans and holocaust survivors. According to these authors, "Persons who work with victims may experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons. We term this process 'vicarious traumatization'" (McCann & Pearlman, 1990b, p. 133).

These writers have developed what they call a "constructivist self-developmental model" (McCann & Pearlman, 1990a, p. 12) for understanding the psychological responses to victimization. They propose that their theory is "a synthesis of developmental theory (Mahler, Pine, & Bergman, 1975), self psychology (Kohut, 1977), social learning theory (Rotter, 1954), and other cognitive theories (e.g., Mahoney, 1981; Piaget, 1971)" (cited in McCann & Pearlman, 1990a, p. 12).

McCann and Pearlman (1990a) have addressed how trauma can disrupt any individual's psychological growth and development. As people grow and develop, they assimilate or integrate their
experiences into their existing schemas. These schemas serve as conceptual frameworks for organizing and interpreting these experiences. Piaget (1971) first described the processes of accommodation and assimilation whereby changes in cognitive schemas take place. When a person encounters new information that cannot be assimilated into existing schemas, cognitive schemas are adjusted by a process called accommodation. The complex interchange and equilibrium between accommodation and assimilation results in the increasing differentiation and maturation of an individual's cognitive schemas, as well as other psychological systems of the self and psychological needs. This growth is called progressive self-development.

McCann and Pearlman (1990a) have stated that trauma challenges individuals to accommodate or modify their cognitive schemas. However, trauma also causes disruptions in psychologically central areas which makes the accommodation process difficult. Therefore, trauma can cause temporary or longer term disruption of an individual's psychological growth.

McCann and Pearlman (1990b) have asserted that the impact of the process of vicarious traumatization on the therapist can be pervasive, cumulative, and possibly permanent. They said, "We understand the effects on therapists as pervasive, that is potentially affecting all realms of the therapist's life; cumulative, in that each client's story can reinforce the therapist's gradually changing schemas; and likely permanent, even if worked through completely" (McCann & Pearlman, 1990b, p. 136).

McCann and Pearlman (1990b) further stated:
It is our belief that all therapists working with trauma survivors will experience lasting alterations in their cognitive schemas, having a significant impact on the therapist's feelings, relationships, and life. Whether these changes are ultimately destructive to the helper and to the therapeutic process depends, in large part, on the extent to which the therapist is able to engage in a parallel process to that of the victim client, the process of integrating and transforming these experiences of horror or violation. (McCann & Pearlman, 1990b, p. 136)

They have maintained that the process of vicarious traumatization is the normal reaction to the stressful, and sometimes traumatizing, work with trauma victims. They have identified the following factors which contribute to the transformational process of vicarious traumatization: the nature of the graphic and painful material shared by the victim; the therapist's unique cognitive schema; the therapist's ego resources, self-capacity, imagery systems within her memory; and the nature of the therapist's support system.

Based on their cognitive self-development theory of personality, they have proposed the following seven fundamental psychological needs and the cognitive representations of these needs called schemas: frame of reference, safety, dependency/trust, power, esteem, intimacy/connectedness, and independence (McCann & Pearlman, 1990a, 1990b; McCann, Pearlman, Sakheim, & Abrahamson, 1988). Their major hypothesis is that trauma can disrupt these schemas, and an individual will experience a trauma in a unique way depending on which schemas are most prominent for that person. They have asserted that treating trauma survivors can also powerfully affect the therapist's fundamental schemas. The specific reactions of a therapist are influenced by the centrality or salience of these schemas to the
particular individual.

The following is a brief review of these seven fundamental needs and disruptions in the therapist's cognitive schemas about self and the world. McCann and Pearlman (1990b) have noted that the therapist's schema disruptions may be "subtle or shocking, depending on the degree of discrepancy between the client's traumatic memories and the therapist's existing schemas" (p. 138).

Seven Basic Needs and Cognitive Schemas

1. **Frame of Reference** is what McCann and Pearlman (1990a, 1990b) call the "suprordinate" need within their theory. It is the basic human need to believe in a meaningful, just, or predictable human world. It is the individual's need to develop a stable, coherent perspective for understanding one's experience. When confronted by traumatized clients questioning, "why did this happen to me?", therapists may attempt to confirm their own frame of reference by designating causality in ways destructive to a client. For example, the therapist may subtly assign blame to the client or may be overfocused on the motives of the perpetrator, ignoring the needs of the client. These authors also noted that if therapists' schemas are continuously challenged by accounts of trauma, therapists can experience a pervasive sense of disorientation (McCann & Pearlman, 1990b).

2. **Dependency/trust** is the need to believe in the word of others and depend on others to meet one's needs (McCann & Pearlman, 1990a). Therapists who treat incest victims are exposed to repeated examples of deception and betrayal of the trust, as well as the cruel
ways people can undermine the trust and safety of those who depend on them. Through such exposure, the therapist's schemas about trust may be disrupted, with resulting suspiciousness or cynicism about people's motives.

3. **Safety** is the "need to feel safe and reasonably invulnerable to harm" (McCann & Pearlm, 1990a, p. 23). Images and stories about harm or threats to innocent people may undermine the therapist's schemas within the area of safety. McCann and Pearlm (1990b) noted that therapists who treat victims of random violence may have a greater awareness of their own vulnerability.

4. **Power** is the need to exert control over others and one's life. Repeated exposure to client's memories of extreme helplessness, vulnerability and powerlessness, can evoke therapist's concerns about her own power or efficacy in the world. McCann and Pearlm (1990a, 1990b) suggested that therapists with high needs for power are likely to experience greater impact from the powerlessness reported by their clients. They noted that this impact can lead therapists to urge clients to take action inappropriately. Some therapists may have protective, or even brutal, retaliatory fantasies. In contrast, other therapists may have a heightened awareness of having no control over unexpected life events. Therapists may find themselves feeling helpless or depressed about the capricious nature of human violence.

5. **Independence** is the sense that one can control one's own behavior and rewards. Trauma victims, such as rape victims, often experience a disruption in their need for independence and personal...
autonomy. Therapists who may identify with their clients' loss of independence may, for example, experience dreams of feeling trapped, or experience concern about possible loss of personal control or freedom.

6. **Esteem** is defined as "the need to view others as benevolent and worthy of respect" (McCann & Pearlman, 1990b, p. 140) as well as "the need to be valued and validated by others" (McCann & Pearlman, 1990a, p. 23). Exposure to accounts of violation and cruelty by other human beings, especially a client's parents, may cause a therapist's view of human nature to become more cynical or pessimistic.

7. **Intimacy/connectedness** is the need to feel connected to others through individual relationships and belong to a larger community. McCann and Pearlman (1990a, 1990b) have noted that trauma victims often experience a pervasive sense of alienation from other people. Frequent exposure to horrific stories of cruelty may stimulate a similar experience of alienation in the therapist. This alienation can be reinforced by the response of other professionals who view their work with revulsion or disbelief. A therapist who is exposed to clients' horrific accounts may also experience a sense of separateness from family and friends. This is also compounded by the requirement of confidentiality, which makes it difficult to disclose disturbing traumatic material. These factors may interfere with a sense of connection with others, which can develop into a therapist's deep sense of alienation.
Comparison of Models

Each of the models reviewed have located the cause of therapist distress in different features of the client, the therapist, and/or their interaction. The burnout literature focused on only the characteristics of the stressor (including the traumatic content) as the cause of therapist distress. The secondary PTSD model also suggested that therapist distress was caused by exposure to the PTSD of incest survivors. PTSD addressed both traumatic content and some relational responses of clients. Various countertransference formulations located the cause of therapist distress in an interaction between the therapist's personal features (e.g. abuse background, gender socialization) and both the traumatic content and many relational process features (projective identifications, role suctions) of treating this population. No one countertransference formulation clearly accounted for all of these features, although Herman's (1992) traumatic countertransference model suggested all of these features.

McCann and Pearlman's (1990a, 1990b) constructivist self-developopmental theory has addressed the interactive effects of the characteristics of the stressor (especially traumatic content) and the therapist's personal features (unique cognitive schema, ego resources, self-capacity, imagery systems, and support system). In this theory the therapist's unique responses are influenced by the characteristics of the population (including content) and the therapist's specific psychological cognitive schemas and underlying needs. A strong feature of their cognitive model is that it accounts for
both the transformation of the victim's cognitive schemas as a result of the original traumatization, as well as the vicarious traumatization process of the therapist. However, their model does not seem to account for some of the distressing relational process features of treating this population which have been explicated by some of the countertransference formulations.

Therapist Rewards in Treating Incest Survivors

Most authors have focused on the difficulties and challenges of treating these incest survivors. Some authors (Briere, 1989; Courtois, 1988) have briefly mentioned that therapists may benefit from treating this population if they work at awareness of their own histories, defenses, and care for themselves. Herman (1992) has addressed the rewards of treating incest survivors, which include having a greater appreciation for life, greater understanding of others and themselves, feeling inspired by survivors' courage, and forming deeper relationships. McCann and Pearlman (1990b) have briefly addressed the ways that working with trauma victims, including incest survivors, has enriched their lives in the following ways:

An outcome of our enhanced awareness of social and political conditions that lead to violence has been greater social activism. Other positive effects include . . . enhanced empathy for the suffering of victims, resulting in a deeper sense of connection with others; increased feelings of self-esteem from helping trauma victims regain a sense of wholeness and meaning in their lives; a deep sense of hopefulness about the capacity of human beings to endure, overcome, and even transform their traumatic experiences; a more realistic view of the world, through the integration of the dark sides of humanity with healing images. (McCann & Pearlman, 1990b, p. 147)
Herman (1992) has also suggested that engaged therapists are constantly fostering integration in clients and themselves, and thus, deepening their own integrity. She stated:

Integrity is the capacity to affirm the value of life in the face of death, to be reconciled with the finite limits of one's own life and the tragic limitations of the human condition, and to accept these realities without despair. Integrity is the foundation upon which trust in relationships is originally formed, and upon which shattered trust may be restored. The interlocking of integrity and trust in caretaking relationships completes the cycle of generations and regenerates the sense of human community which trauma destroys. (p. 154)

Summary

What are some of the common findings in the literature about the responses of female therapists in treating incest survivors? Many authors (Bernstein, 1989; Bigras, 1990; Briere, 1989; Courtois, 1988; Courtois & Sprei, 1988; Courtois & Watts, 1982; Ganzarain & Buchele, 1986; Gelinas, 1981, 1983; Gil, 1988; Herman, 1981, 1988, 1992; Levine, 1990; Lisman-Pieczanski, 1990; MacCarthy, 1988; McCann & Pearlman, 1990; Sprei, 1987) have noted that therapy with survivors of childhood incest is difficult work for the therapist as well as the client.

Current models addressing the impact on therapists treating incest victims have been discussed including burnout, countertransference and secondary post-traumatic stress disorder, traumatic countertransference, and vicarious traumatization. Many authors have discussed countertransference patterns with incest victims. Some writers (Bigras, 1990; Briere, 1989; Herman, 1981) have noted when
treating incest survivors that male and female therapists have different gender related countertransferences which can seriously undermine the therapy. Briere (1989) has noted that due to exposure or awareness of vulnerability to victimization, female therapists may be prone to a countertransference of overidentification with the client's victimization. Female therapists may respond with two overidentification patterns, namely of overinvolvement or underinvolvement. The countertransference pitfalls noted by Bernstein (1989) of first denial and later being caught in the client's frightening reality could be forms of under or overinvolvement. Sprei's (1987) four defensive patterns observed in group therapists bear some similarity to the two forms of overidentification noted by Briere (1989). However, it is difficult to compare these two conceptualizations since they are based on the experiences of therapists in group rather than individual therapy.

Of the sources reviewed earlier in the literature, it appears that only Briere (1989) explicitly uses the traditional view of countertransference as being therapist behaviors which are biased by earlier life expectancies and learning. Others (Catherall, 1991; Ganzarain & Buchele, 1986, 1988; Herman, 1992; Levine, 1990; MacCarthy, 1988; McCann & Pearlman, 1990a, 1990b; Peebles-Kleiger, 1989) appear to use countertransference in the broader sense as being the therapist's total response experience with a client, especially referring to the powerful countertransferences that can be induced in most therapists by this client population. Recent formulations by psychoanalytic theorists (Aron, 1992a, 1992b; Hirsch, 1992) have
explored the two person psychology between therapist and client and the reciprocal contributions each makes to transference and counter-transferences in their dynamic relationship. This view appears to be more useful in accounting for the complex response patterns engendered in the therapist by the impact of often horrific abuse memories, the client's powerful relational process dynamics (including dissociative or splitting defenses), projective identifications, and frequent role suctions.

Some writers (Briere, 1989; Herman, 1981) have noted that therapists can experience PTSD by proxy, regardless of gender. Herman (1992) has recently offered a formulation of the traumatic transfersences produced by trauma survivors suffering from traumatic syndromes, as well as the range of traumatic countertransferences experienced by therapists treating such clients. Colrain and Steele (1992) maintained that therapists treating survivors of sexual abuse commonly experience symptoms of secondary post-traumatic stress disorder. They have identified a long list of therapist behaviors which are possible indicators of secondary PTSD in therapists.

McCann and Pearlman (1990a, 1990b) make the dramatic assertion that therapists' fundamental cognitive schemas can be altered in lasting ways by working with trauma survivors by a process termed vicarious traumatization. Their work is based on observations of therapists treating many types of trauma victims, including incest survivors. Would such disruption in these fundamental schemas be evident in interviews with female therapists about their experience of treating incest survivors? MacCarthy (1988), a male analyst,
noted the "leaden sense of inner desolation" (p. 120) he has felt with treating incest victims. Both he and Rosenfeld (1987) another male analyst, gave up working with incest victims after 12-15 years of experience because of their "inner desolation" and burnout experienced with these clients. MacCarthy wondered whether his decision was also a response to countertransference hate. After 17 years of treating survivors of severe childhood sexual abuse, Rene Frederickson (personal communication, November 8, 1991) reported that she will no longer treat incest victims in individual therapy, rather choosing group therapy with a co-therapist, because of her difficulty dealing with traumatic material when seeing such clients alone. She said, "I do not want to hear about another murder when alone with a client."

Are the decisions of these therapists a response to their countertransferences, possibly traumatic countertransference, or an expression of lasting changes in their cognitive schemas resulting from vicarious traumatization? Would experienced female outpatient therapists who have treated adult female incest survivors for over 8 years demonstrate lasting changes in their cognitive schemas resulting from a vicarious traumatization process?
CHAPTER III

DESIGN OF THE STUDY

The review of the literature has demonstrated that psychotherapy with incest survivors can be difficult and taxing work for the therapist. A range of therapist behaviors, conceptualized as responses to burnout, countertransference, traumatic countertransference, secondary PTSD, and vicarious traumatization have been reviewed. The possible negative effects on the therapist and the course of therapy have been addressed in Chapter II within the review of each of these conceptualizations. Although there are anecdotal reports, it appears that there have not been any formal studies to date of the responses of female therapists to treating incest survivors. There also have not been any studies exploring whether female therapists may experience any lasting effects in their cognitive schemas, resulting from vicarious traumatization, after many years of working with incest trauma survivors.

Do female therapists experience vicarious traumatization as a result to treating adult female incest survivors, as McCann and Pearlman (1990b) maintain? Would female therapists with at least 8 years experience treating this client population report any signs of such vicarious traumatization in the form of lasting changes in some of their seven cognitive schemas identified by McCann and Pearlman (1990a, 1990b)? Given the large percentage of incest survivors
presenting for outpatient treatment, a study addressing these ques-
tions would be helpful for clinicians providing such treatment, their
supervisors, and those involved in training therapists.

A qualitative study of female therapist responses to treating
adult female incest survivors is appropriate at this stage in theory
building regarding the effects of treating such clients on female
therapists (Marshall & Rossman, 1989). A focused, yet flexibly
designed exploration and analysis of female therapists' experience
may yield additional knowledge about their response processes. As
suggested by Isaac and Michael (1989), a qualitative study may pro-
vide background information for planning future psychological stu-
dies, test the adequacy of current conceptualizations, reveal vari-
ables and interactions that deserve more extensive attention in our
understanding of one aspect of treating adult female incest survi-
vors, and provide important results for theory building.

In a qualitative study using structured interviews, this study
asked experienced female outpatient therapists to describe aspects of
their experiences in treating adult female incest survivors and to
reflect on how their work with this population may have influenced
some of the cognitive schemas identified by McCann & Pearlman (1990a,
1990b). It attempted to validate, deepen, and/or expand the con-
ceptualizations already discussed in Chapter II. It also discovered
some additional features in the responses of female therapists to
treating this population which have not yet been emphasized in the
literature.
Underlying Assumptions

Before proceeding further, it may be helpful to identify some of the assumptions underlying the choice of a qualitative methodology for this study. The following assumptions serve as basic principles for the naturalistic or qualitative paradigm which will guide this study. "Paradigm" (Kuhn, 1970) here is taken to mean a systematic set of principles guiding a theory, with congruent methods.

As suggested by Lincoln and Guba (1985), this study is based on the assumption that reality is not a single, tangible entity which can be neatly fragmented into variables able to be predicted and controlled. Rather, there are multiple realities and meanings constructed by the subjects involved. Although prediction and control is not the purpose of this study, a qualitative study can offer a level of meaningful understanding, possible only if subjects are permitted to discuss freely their experience. This study also assumes that the researcher and the object of the inquiry interact influencing one another. Both participants in an experience are constantly and mutually shaping one another so that distinguishing causes and effects is impossible. Finally, all inquiry is influenced by many values, those of the researcher, of the choice of paradigm guiding the investigation and subsequent analysis, and by the values of the context or subjects of the study.

Method

The method and design of this study received the approval of the
Human Subject's Institutional Review Board at Western Michigan University in June, 1992.

This study used an interviewing method called the long interview. The long interview has special strengths and advantages for this research. This method involves the researcher spending 2 to 6 hours with a respondent exploring her experience using a structured questionnaire. As McCracken (1988) has stated,

> For certain descriptive and analytic purposes, no instrument of inquiry is more revealing. This method can take us into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world. It can take us into the lifeworld of the individual . . . to see and experience the world as they do themselves. (p. 9)

The long interview offers a flexible procedure with which to capture the respondent's experiences and understanding of her experience with female incest survivors. It can do so in a way that requires neither the researcher nor the respondent to make great sacrifices in time or privacy. In this study the researcher interviewed each subject for about 2 hours.

The Structured Interview

An interview format was designed with a series of questions asking experienced female outpatient therapists to reflect on their therapy experiences with adult female incest survivors and to ascertain the therapists' experiences of any lasting changes in any of the seven cognitive schemas discussed earlier. The interview contained a series of questions asking the subjects to describe dimensions of their experience treating adult female incest victims. For each
question, there was a series of prompts which could be used in a planeful way to explore the respondent's experience. Although the interview was structured, it allowed opportunity to explore unstructured responses and to take advantage of the contingencies of the interview (McCracken, 1988). The structured interview used in this study is found in Appendix A.

The questions about lasting changes in the seven cognitive schemas used the definitions of each schema given by McCann and Pearlman (1990a, 1990b). These questions asked the subjects to reflect on whether treating this client population has prompted lasting changes in their beliefs about self or their clients in each schema area. The questions were open ended enough to allow the subjects to share any aspects of their experience in that area in their own terms.

Since McCann and Pearlman (1990a, 1990b) used two definitions of esteem, the structured interview included two sets of questions in the area of esteem, rather than one. These two sets of questions explored their two different ways of defining esteem: (1) beliefs that one can be valued and validated by others, and (2) beliefs in the benevolence of others and that others are worthy of respect. Since these two definitions contained distinct features regarding esteem, both were included in separate questions.

Development of the Structured Interview

The researcher pilot tested the structured interview with two respondents. The first version of the structured interview included
sets of four sub-questions for each of the questions dealing with six cognitive schemas (Questions 3-8 dealing with safety, trust/dependency, esteem, independence, power, and intimacy/connectedness). These sub-questions asked the therapist to reflect on whether she had noticed any lasting changes in a particular schema, such as safety or trust, for herself, for her significant others, for her clients, and her clients' significant others. The two therapists responding to the pilot interviews had difficulty understanding and responding to the sub-question about their clients' significant others. They also seemed to find the sets of four sub-questions repetitive and laborious. The researcher found that their interest and energy for the task waned in this section of the interview. As a result, the sub-questions in Questions 3-8 about the clients' significant others were deleted in the final interview. The sub-questions about the therapists' significant others were condensed into one question, namely Question 10 in Appendix A.

In Questions 3-9, the initial version of the structured interview were phrased using the word "expectation" when asking therapists whether, for example, they had noticed any lasting changes in their expectations that their clients could believe what others tell them and trust others. In the two pilot interviews the therapists frequently made comments about not wanting to have expectations for others, and seemed to lose the focus of the question. Since McCann and Pearlman (1990a, 1990b) used the words "expectations, assumptions and beliefs" interchangeably, the word "belief" was substituted for "expectation" in the final version of the structured interview.
The pilot interviews did not include enough questions giving therapists opportunity to talk about some of the therapist responses discussed in the literature, namely physical responses, influence on therapists' dreams, and experiences of transferences and counter-transference. Questions 12, 13, and 14 were added to provide the subjects an opportunity to comment on their experiences in these areas. Question 14 which was phrased, "Have you noticed that these clients position you or place you psychologically in any particular roles?" was designed to elicit comments about the subjects' experience of transference-countertransference in the therapy relationship. The term "countertransference" was avoided intentionally in the phrasing of this question. Informal testing of some interview questions with therapists revealed that some therapists became defensive when the term "countertransference" was used. The alternative phrasing of Question 14 elicited the intended material without any hesitation from the subjects. In the final version, Question 15 was also added, namely "What are the most effective professional and personal ways that you use to help you deal with the challenges of treating this client population?"

The Researcher as Instrument

When using a qualitative methodology, the investigator served as a kind of instrument in the collection and analysis of the data. In order to fulfill the objectives of this research design, the investigator used her own experience as a therapist and knowledge of this client population in the process of sifting through the data and
searching for patterns. McCracken (1988) stated that the "self-as-instrument works most easily when it is used simply to search out a match in one's experience for ideas and actions that the respondent has described in the interview" (p. 19). In dialogue with her research advisor, the investigator also identified and clarified her own experiences and biases in order to more easily identify new propositions and assumptions in treating adult incest survivors which were suggested by the subjects.

Selection of Subjects

The study intended to select and interview a sample of three experienced female outpatient therapists. Twelve community-based outpatient therapy practices were selected randomly from the 30 such practices in a mid-size, mid-western city. A total of 31 female therapists in these 12 randomly selected practices received an initial letter (Appendix C) describing the study, inviting them to participate, and asking them to return the background data sheet which provided information for screening subjects (Appendix B). They also received an Informed Consent Form (Appendix D) which informed them of their participant rights. Female therapists were selected who met the following criteria: each had a master's level training (M.A., M.S.W., M.S.) as a psychotherapist, had over 8 years experience providing outpatient therapy for adult female survivors of incest, currently had incest survivors as outpatient clients, and had no prior relationship to the researcher. Only one therapist from a particular practice was selected for an interview to reduce the
possibility of contagion between subjects.

The selection of pilot subjects and subjects for interviews were done in two stages. While the 12 practices were selected randomly, the selection of subjects from among the pool of seven respondents was not random. From a possible 31 female therapists, a total of 7 female therapists responded to the invitations to participate in the study which were mailed in August, 1992. Among the first three respondents, one was not selected because she did not have 8 years experience. Since the other two respondents met the selection criteria, they were selected to pilot and refine the structured interview. These interviews were transcribed, as later described, and used as data to test and improve the structured interview and develop the coding categories.

After these two pilots were under way, an additional three therapists responded to the invitation. These three were chosen as subjects for the interview in its final form because they not only met the screening criteria, but also proved to be fairly homogeneous in terms of educational background, years of experience, and age range (see Characteristics of Subjects).

After interview times were scheduled with these three subjects, an additional therapist responded to the invitation. She was not chosen because she was a colleague in a practice with Subject 2. She was the only respondent who had an M.A. degree, rather than an M.S.W. degree and training like all the other respondents. The two respondents who were not chosen to be interviewed received a letter informing them that they had not been selected and would receive a
summary of the study's findings.

The purpose of sampling for this study was to select three experienced female outpatient therapists who volunteered to reflect on their experience with adult female incest survivors and whose experience may be typical of female outpatient therapists. The purpose of the study was to provide a rich multi-faceted description of three female therapists' experience with adult female incest survivors, detailing many facets of their experience which might illuminate the range of responses, including burnout phenomenon, countertransferences of female therapists, traumatic countertransference, secondary PTSD, and possible lasting effects of such work on the female therapists' cognitive schemas.

Characteristics of the Subjects

The three subjects selected represented a homogeneous sample since they shared many additional similarities. The three subjects were Caucasian and had an M.S.W. degree and background. They ranged in age from 37 to 46 years. They all had 10 years experience treating adult female incest survivors in outpatient settings. They all had additional years of experience treating other populations. They reported that adult female incest survivors constituted between 30%-50% of their case loads. All subjects reported treating incest survivors who displayed levels of dissociation. Two of the subjects specifically mentioned treating clients diagnosed with multiple personality disorder (MPD), and the third implied that she also treated such clients, but was more skeptical about the prevalence of
the symptoms warranting this diagnosis. The three subjects were interviewed with the structured interview questionnaire in its final form.

All of the therapists who participated in this study were social workers with M.S.W.s. There were no psychologists used as subjects for this study or for the pilot testing of the structured interview. Although the invitations to participate in the study were sent to female therapists who had different types of master's level training (M.S.W., M.A., M.S.), six of the seven respondents had M.S.W.s.

Researcher/Subject Relationship

The researcher tried to foster a relationship with each subject which protected her rights as a subject (also see The Structured Interview). Prior to the interview each subject received and signed an Informed Consent Form (Appendix C) as a way of informing her and protecting her rights. The subjects chosen did not have a prior relationship with the researcher. Each interview took place at each subject's place of work to ensure a comfortable setting for the subject.

The Interview

The researcher fostered a relationship with each subject which respected her rights and privacy. After explaining the purpose of the research and interview, the researcher explained to the subject that she was free to respond to the depth and extent that she chose on any of the questions, that she was free to skip any questions
without further comment; and she was free to stop the interview or withdraw from the research project at any time. If the researcher observed behavior in the subject which suggested discomfort, the researcher was prepared to ask the subject if she wished to continue with that question. At the end of the interview all the subjects made comments about being comfortable with the interview and found the questions very relevant to their work with this population. Two of the subjects asked to stop the interview briefly to get something to drink. None of the subjects asked to skip any of the questions or withdraw from the research project. The interviews lasted about 2 hours.

The researcher began with more open-ended questions and proceeded to explore specific dimensions of the therapist's experience along the seven cognitive schemas (see Appendix A). In addition to the questions and prompts identified on the structured interview, the researcher had the latitude to explore therapist responses on salient aspects of the therapist's experience which had not been anticipated. The researcher exercised judgment on limiting such exploration to maintain the parameters of the study.

Data Collection and Management

The pilot interviews were done in August and September, 1992. The structured interviews with the study's three subjects were done in October, 1992. The interviews were audiotaped and transcribed so that trained readers (see below) could review and code the contents. To maximize accuracy and familiarity with the interview data in the
shortest time, the researcher also transcribed the audiotapes. These audiotapes were not heard by anyone other than the researcher. After transcription, the audiotapes were stored in a locked cabinet in the researcher's home.

In order to protect the identity of subjects, a code number for each subject was assigned to the audiotapes, transcripts of the interviews, and background information form. Any identifying information (i.e., names, towns, places of employment) included in the interview was disguised by substituting pronouns, generic terms, and fictitious initials. Background information on the subjects, interview transcripts, and computer discs containing the transcripts were kept in a locked file cabinet in the researcher's office.

Development of Unique Coding System

A Unique Coding System was developed for each of the seven cognitive schemas identified by McCann and Pearlman (1990a, 1990b). For each cognitive schema, examples of lasting change, or vicarious traumatization, were identified from their research (McCann & Pearlman, 1990b) and listed using their language as an example of lasting change within that schema. The definitions given by McCann and Pearlman (1990a & 1990b) were used for each of the cognitive schemas.

In this early stage in the development of the coding system, lasting change was conceived as occurring only in a negative direction and as representing vicarious traumatization. This coding system was used, first by the researcher to code some of the responses of the two pilot interviews. The researcher found that these
subjects reported lasting changes as a result of treating this population in many of their cognitive schemas occurring in both negative and positive directions. The frequency of this kind of reported positive change was an unexpected finding and required the development of the Unique Coding System (see Appendix E).

The coding system was developed to include examples of positive lasting change in each of the seven cognitive schema. These examples were developed as logical extensions in a positive direction from the negative examples identified by McCann and Pearlman (1990b). Samples of language from the pilot interviews which demonstrated the positive lasting changes were included under each cognitive schema.

In the final form, the Unique Coding System outlined the criteria for codification of each cognitive schema, identifying criteria demonstrating Lasting Change - Negative (LC-), Lasting Change - Positive (LC+), and No Change (0), for each cognitive schema.

Some of the examples of negative lasting change were not as dramatic or startling as those cited in the stories of vicarious traumatization reported by McCann and Pearlman (1990b). However, the samples of language coded as demonstrating either positive or negative lasting change were judged by both readers to be of a similar nature to the statements of what constituted negative lasting change or vicarious traumatization in each of the cognitive schemas identified by McCann and Pearlman (1990b). Samples of subjects' language demonstrating positive and negative lasting change in the seven cognitive schemas are found in the Unique Coding System (Appendix E).
Readers

One of the readers was the principal researcher. The second reader was a female therapist with an M.S.W. and over 10 years experience treating this client population. This reader completed a training program with the principal researcher (see below). A second female reader was chosen because of the strengths of maintaining one gender throughout the study. It was recognized that each person, regardless of gender, brings his or her own bias to the interpretation of the transcribed interviews. It was hoped that the female readers read and evaluated the respondents' narratives from what Gilligan (1982) refers to as a similar voice.

Training

The second reader completed a training program conducted by the principal researcher. This training included a review of the purpose of the study, of the directions given the respondents and structured interview, as included in Appendices A, B, C, and D. The reader was instructed on the coding system for each set of questions. The reader and principal researcher practiced scoring the pilot interviews and reviewed their results. Scores and reasoning behind decisions were discussed sufficiently so that the two readers had a reasonable level of understanding, agreement, and accuracy.

Inter-rater Reliability

Determining inter-rater reliability took place according to the
following procedure. Each reader examined a subject's narrative in each of the seven cognitive schemas about the subject's beliefs about herself and her clients, coding their responses as demonstrating Lasting Change in a negative direction ($\text{LC}^-$), Lasting Change in a positive direction ($\text{LC}^+$), or No Lasting Change (0) as a result of treating this population. Working separately, each reader recorded the codifications on a coding sheet. Next, the two readers compared their codifications for the 48 coded units for the three subjects.

Inter-rater reliability between the readers was .93. The percentage of inter-rater agreement was calculated prior to the resolution process. To calculate reliabilities, the following formula was used:

\[
\text{Number of agreements} \div \text{Number of agreements} + \text{Number of disagreements}
\]

The two readers agreed on 45 out of 48 coded units. According to the above formula the inter-rater reliability was .93. Such a high inter-rater reliability suggested that the coding system could be utilized accurately between readers.

Whenever there was disagreement, such differences were discussed between readers and resolved to 100% agreement. The disagreement on three codeable units was resolved by contacting two of the subjects to clarify their responses. Subject 1 was asked to clarify Question 3b. Subject 3 was asked to clarify Questions 8a and 10. The principal researcher wrote the subjects about the question(s) needing clarification, and asking for a brief phone response. Subject 1
responded by letter giving the necessary clarification. Subject 3 responded with a phone call. These clarifying responses were transcribed and added to their responses for the codeable units in question. The two readers then coded these units a second time, compared their codification, and had agreement on these units. The results of this codification are summarized in Table 1 (Chapter IV).

Data Analysis

The data was analyzed by a process of internal content analysis, "a process aimed at uncovering embedded information and making it explicit" (Lincoln & Guba, 1985). The following two sub-processes were used: coding and theme summary. For each of the sub-questions about a cognitive schema which constituted a codeable unit, the transcribed interviews were systematically examined by the readers for statements which met the criteria for the codes developed in the Unique Coding System (see Appendix E). The results of this coding process were summarized in Table 1. The other general questions were each examined for themes among the three subjects. Common themes among the general questions were summarized. Finally, these findings were used to respond to the research questions and hypotheses identified in Chapter I.

Limitations and Strengths of the Study

As with any study, the limitations of this study need to be acknowledged. The data depends on the therapists' retrospective recollection of their responses in treating adult female incest
survivors, as well as their willingness to disclose this information. Informal testing of some questions for the interview questionnaire revealed that therapists were willing to respond candidly and openly about their experiences.

The qualitative nature of the design does not provide data which can be generalized to a regional or national population. Given the anecdotal nature of the literature on therapist responses with this population, this study does provide a rich description of experienced female outpatient therapist responses to treating adult female incest survivors which has promising utility. First, it is one of the first formal studies of this issue. It provides some additional knowledge about the complexities and processes involved in therapist responses with this client population. It provides data which supports aspects of the McCann and Pearlman (1990a, 1990b) model of vicarious traumatization. It also reveals a new variable or effect on experienced female therapists as a result of treating this population which deserves more extensive attention in future studies.
CHAPTER IV

ANALYSIS

The task of this study has been to examine the self-reported responses of experienced female outpatient therapists to treating adult female incest survivors for evidence of lasting change in the cognitive schemas identified by McCann and Pearlman (1990a, 1990b), and examined for support for their model of vicarious traumatization. The task included a comparison of what experienced outpatient therapists reported to be the most demanding features of treating this population 10 years ago with what they currently find to be the most demanding features. The researcher also proposed to examine the data for any additional variables which may not have been addressed in the literature.

The subjects' interviews were analyzed in the following ways. First, the subjects' responses to the questions about lasting changes in their cognitive schemas (Questions 3-10) have been analyzed according to the method described earlier and the results have been summarized and documented. Second, each of the general questions (1-2, 11-18) have been examined, and themes within each question have been summarized. Third, common themes among the general questions have been summarized and discussed. Finally, these findings have been compared to the original research questions and hypotheses identified in Chapter I.
Analysis of Questions About Cognitive Schemas

The subjects' responses to the questions pertaining to lasting changes in their seven cognitive schemas, namely safety, trust/dependency, esteem, independence, power, intimacy/connectedness, and frame of reference (McCann & Pearlman, 1990a, 1990b) have been analyzed according to the qualitative method discussed in Chapter III. The Unique Coding System for the seven cognitive schemas found in Appendix E was used to produce the codification of the subjects' narratives found in Questions 3-10. The results of the codification process have been summarized in Table 1.

Table 1

<table>
<thead>
<tr>
<th>Lasting Changes in Cognitive Schemas</th>
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<tbody>
<tr>
<td><strong>Subjects</strong></td>
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<td>-------------------------------------</td>
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<tr>
<td>Cognitive Schemas</td>
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<tr>
<td>#1</td>
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<td>#3</td>
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Q3. Safety

A. Self

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<tr>
<td>LCC-</td>
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B. Safety

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<th>Cognitive Schemas</th>
<th>#1</th>
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<tr>
<td>LCC+</td>
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Q4. Trust/Dependency

A. Self

<table>
<thead>
<tr>
<th>Cognitive Schemas</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
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<tbody>
<tr>
<td>LCC-</td>
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B. Clients

<table>
<thead>
<tr>
<th>Cognitive Schemas</th>
<th>#1</th>
<th>#2</th>
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<td>LCC-</td>
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Q5. Esteem

1. Being Valued

A. Self

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<tr>
<th>Cognitive Schemas</th>
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<th>#2</th>
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<td>LCC+</td>
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<th>Cognitive Schemas</th>
<th>Subjects</th>
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<tr>
<td></td>
<td>#1</td>
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<tr>
<td>B. Clients</td>
<td>0</td>
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<tr>
<td>2. Others are benevolent</td>
<td></td>
</tr>
<tr>
<td>A. Self</td>
<td>0</td>
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<tr>
<td>B. Clients</td>
<td>0</td>
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<td>Q6. Independence</td>
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<td>B. Clients</td>
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<td>Q7. Power</td>
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<td>B. Clients</td>
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<td>Q8. Intimacy/Connectedness</td>
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<tr>
<td>A. Self</td>
<td>LC-</td>
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<tr>
<td>B. Clients</td>
<td>LC-</td>
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<tr>
<td>Q9. Frame of Reference</td>
<td></td>
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<tr>
<td>A. Self</td>
<td>LC-</td>
</tr>
<tr>
<td>Q10. Significant others</td>
<td>LC-</td>
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</table>

0 = No change  
LC- = Lasting change-negative  
LC+ = Lasting change-positive

The following is a summary of the questions exploring lasting changes in each of the cognitive schemas, the subjects' responses.
which corroborate the codification, and a summary of any common response patterns within each cognitive schema.

Question 3. Safety

3a. As a result of your experience treating adult female incest survivors, have you noticed any lasting changes in yourself in your sense of feeling safe, or of feeling reasonably invulnerable to harm?

Subjects 1 and 3 both reported lasting change in their sense of feeling safe, with Subject 1 reporting a negative change and Subject 3 reporting a positive change. Subject 1 stated:

I have an entirely different concept of evil in the world. I am much more aware of how indiscriminate evil can be.

... So I would say that I am much more paranoid at times, much more aware of how I could be on the receiving end. ... I read the newspaper differently. I see crimes against women in ways that I didn't. ... I've grown enormously in my sensitivity to the issues, and for my own safety. I'm more careful.

Subject 3 stated:

If anything, I feel more safe now than I used to. ... I'm thinking about how I've changed in 10 years ... that my work as a therapist, probably especially with such a challenging population, but in general, is growth producing.

... So I would see myself as less fearful than I used to be ... knowing that fear has been an issue in my life.

The response of Subject 2 did not demonstrate a lasting change as a result of treating this population. She stated, "I certainly don't feel invulnerable to harm, but I attribute that more to age than to my work with survivors. I don't think my work with survivors has changed my own personal sense of safety." She goes on to say that she is very aware of the issue of safety, and "it's been much more clearly brought up to me by my work with these people."
3b. As a result of treating this population, have you noticed any lasting changes in your belief that your clients can be safe, in your sense that they can be reasonably invulnerable to harm?

All three subjects reported a lasting change in their belief that their clients can be safe. Subjects 1 and 3 both reported positive lasting change in their beliefs that their clients can be safe, while Subject 2 reported a negative lasting change. Subject 2 stated, "Yeah, I would say that it [working with this population] has made me less sure that they can be safe, because of how much work it takes [in] that interchange so that they can take better care of themselves in relationships." In contrast, Subject 3 stated that, "Yes, I think I believe that people have the capacity to be more safe than they think they can be. . . . I think people, largely through the safety and consistency of the therapeutic relationship, can experience more about that." She credited what she called "some long-term change" to "both seeing people develop in their own sense of strength and power and what I believe from my own experience."

Subject 1 stated,

It's kind of paradoxical, because while my sense of vulner-ability has increased, I work very hard to decrease their sense of vulnerability. . . . And so I am about the task of teaching that there are people in the world that can be safe, and how to tell the difference.

She stated that she did not have this position when she began treating this population.

In the cognitive schema of safety, there was a cluster of lasting change. Of the six codable units among the three subjects having to do with beliefs about safety of self or clients, five units
demonstrated lasting change, three positive changes, and two negative changes. Two of the subjects demonstrated lasting change for both themselves and their clients, and one subject demonstrated lasting change in her beliefs about her clients' safety. Only Subject 1 demonstrated negative lasting change in her beliefs about her own safety, while Subject 2 demonstrated negative change in her beliefs about her clients. Subject 3 demonstrated positive lasting change about her beliefs about both herself and her clients, while Subject 1 also demonstrated positive change about her beliefs about her clients' safety.

**Question 4. Trust/Dependency**

4a. As a result of your experience treating this client population over the last 10 years, have you noticed any lasting changes in yourself about your sense that you can believe what others tell you, trust others, and depend on them to meet your needs?

Both Subjects 2 and 3 reported negative lasting changes in their sense of trust. Subject 2 stated:

I have less trust over these years, and don't expect people are telling me the truth as I used to. . . . I would say that it is even 75% from . . . my work with incest survivors and my relationships with people who are incest survivors, but aren't necessarily my clients.

Subject 3 stated:

I think with repeated exposure to people who have been damaged, you know, by people who are supposedly trustworthy in their life, I guess it has had a change. . . . I think I've been continually reminded of how much people can abuse trust. So I guess that has had a lasting impact on me. I think that . . . not much surprises me. I basically don't think you can take too much on face value.
Subject 1 did not demonstrate a lasting change because she did not attribute the negative lasting change she identified to treating this population, but rather to "growing up." She stated:

I don't know if it's related to working with this population or not, but whether it's just a maturing process where you recognize necessarily what's said on the surface isn't what's meant underneath. . . . I'm probably more skillful at not immediately believing everything that I'm told. But that might just be growing up.

Two subjects demonstrated a lasting change in the negative direction in their own sense of trust attributing a large part of this lasting change to treating this population. The other subject reported a negative lasting change in her sense of trust, but suggested that the change was due to "growing up," rather than treating this population.

4b. As a result of treating this population, have you noticed any lasting changes in your belief that your clients can believe what others tell them, trust others, and depend on others to meet their needs?

Only Subject 2 demonstrated a negative lasting change in her belief that her clients can trust others. She stated: "I would also say that I have less belief that they can trust and depend on others to meet their needs, because of what I've learned in working with them."

Subjects 1 and 3 did not demonstrate a lasting change in their belief that clients can trust others. Subject 3 clearly stated that she has had a "pretty constant" belief that "my clients can develop different skills and abilities to determine who is trustworthy."
Subject 3 did not indicate whether her beliefs represented a lasting change from an earlier position and so her response was coded "no lasting change." She stated:

Again, I think that's very much what therapy is about. Because essentially if you look at it from an Ericksonian point of view, their passage through trust and mistrust was impaired, and so they basically don't trust anyone. . . . I challenge that belief in my clients repeatedly, and teach them techniques for how to begin to discern what is truthful and what isn't.

In the area of trust/dependency, a common response pattern among the three subjects was that no positive lasting changes were reported in beliefs about self or clients in the area of trust. Either no lasting change or negative lasting change was demonstrated by all subjects in all the codeable units. Subject 1 did not demonstrate lasting change in her beliefs about trust for herself or her clients. Subject 2 demonstrated a negative lasting change in this area for both herself and clients. Subject 3 demonstrated a negative lasting change for herself in the area of trust.

Question 5. Esteem

1a. As a result of treating this population, have you noticed any lasting changes in your belief that you can be valued and validated by others?

Only Subject 2 demonstrated a positive lasting change in her sense of esteem about herself. She stated, "It's not all from working with these people, but I think there's an increased sense that I can be valuable and be valued by others, because I have seen the impact that I've made on these people."
The responses of Subjects 1 and 3 did not demonstrate lasting change in their sense of esteem about self. Subject 1 stated, "No" [there was no lasting change]. Subject 3 stated, "I don't think I can pinpoint any particular change. . . . I have more of a sense that's been pretty steady."

5-1b. Again, in the area of esteem, as a result of treating this client population, have you noticed any lasting changes in your beliefs that your clients can be valued and validated by others?

Only Subject 2 demonstrated a positive lasting change in her sense of esteem about her clients. She stated that she has had a "steady, growing conviction" over the last 10 years.

that they [incest survivors] can be much more valued by others than they felt at the beginning of treatment. They do have to be cautious about what they ask for from others, in that respect too, and how much they lay their own sense of esteem on other people's views of them.

The responses of Subjects 1 and 3 did not demonstrate lasting change in their sense of esteem about their clients. Subject 1 stated that "I started with the assumption that they could be [valued], and that has never been challenged." Subject 3 stated, "I think that my belief that they can be is pretty consistent. . . . It's reinforced that it is extremely difficult for that population."

5-2a. As a result of treating adult female incest survivors, have you noticed any lasting changes in your belief in the benevolence of others, of human beings, and that they are worthy of respect?

Subject 2 demonstrated a negative lasting change in her beliefs in the benevolence of others. She stated, "There's been a decrease
in that definitely. . . . I'm just wiser . . . through listening to
the experiences of these people who, inadvertently sometimes, were
abused by others, who'd look like pretty fine, respectable people."

The responses of Subjects 1 and 3 did not demonstrate a lasting
change in their belief in the benevolence of others. Subject 1
stated, "I don't think that's changed much . . . if anything, this
has reinforced some of my beliefs." Subject 3 stated that this has
been "a pretty constant value. I can't say that I've seen any signi-
ficant change on that."

5-2b. Also, in the area of esteem, as a result of treating this
population, have you noticed any lasting changes in your belief that
your clients can expect others to be benevolent and worthy of re-
spect?

Subject 3 demonstrated a positive lasting change in her belief
that her clients can expect others to be worthy of respect. She
stated that her work with this population has "enhanced that somehow.
. . . I'm sure that's part of why I'm in the business, but [her
beliefs have been] enhanced."

Subjects 1 and 2 did not demonstrate lasting change in their
beliefs that their clients can expect others to be worthy of respect.
Subject 1 clearly stated that "I don't see any big change there. I
have the expectation that they will treat people in the way they
would wish to be treated." The response of Subject 3 did not clearly
indicate a lasting change as a result of working with population or a
change from an earlier position, and so was coded as "no change."
Subject 3 stated:
They have such a lack of trust in the first place, that my belief is that they can expect at least a slightly higher level of benevolence than they do, and that they can grow in that ability to expect others will be accepting of them.

In the area of esteem, a common response pattern among the three subjects was not apparent. Subject 1 indicated no lasting change in her beliefs about esteem for herself or her clients. Subject 3 indicated a positive lasting change in her beliefs that her clients can expect the others to be worthy of respect. Subject 2 demonstrated lasting change in three out of the four ways of viewing esteem. She indicated positive lasting change in her beliefs that both her clients and herself can be valued. She indicated negative lasting change in her belief in the benevolence of others.

Question 6. Independence

6a. As a result of treating adult female incest survivors, have you noticed any lasting changes in yourself in your beliefs about your freedom, independence and ability to make your own choices?

Subject 3 demonstrated a positive lasting change in her beliefs about her own independence. She said that her beliefs in this area have been "strengthened." She stated,

I can't imagine that it hasn't had some impact on me ... where that's part of my work to see myself always in a personal growth process, so I'm sure there's been much of that. ... So it has had an impact, positive, I mean a growth-producing impact for me as well, I'm sure.

Subjects 1 and 2 did not demonstrate a lasting change in their beliefs about their independence. They both clearly stated, "No" in response to this question. They did not elaborate.
6b. As a result of working with this client population, have you noticed any lasting change in your beliefs that your clients can have freedom, independence, and the ability to make their own choices?

None of the subjects demonstrated a lasting change in their beliefs that their clients can have independence. Subject 1 clearly stated, "No" in response to this question and did not elaborate. Subjects 2 and 3 stated their views of their clients' ability to have independence, but did not demonstrate that this was a change from an earlier position. Subject 2 stated,

It's kind of hard to say. . . . Sometimes I don't see them as very free to make their own decisions. But the only thing I can say is that as they heal, there is an increased sense of freedom, and I believe that they can continue to be more autonomous as they heal.

Subject 3 stated "I think it's a hard road for folks. . . . I have pretty strong beliefs . . . [that] people can get through. . . . People can grow . . . change, unlearn. . . . I have an optimism for people."

In the area of independence, the responses among the three subjects suggested a pattern of little or no lasting change in their beliefs about independence for themselves or their clients. None of the subjects reported any negative lasting change in their beliefs about themselves or their clients. One subject reported positive lasting change in her beliefs about independence for herself.

Question 7. Power

7a. As a result of treating adult female incest survivors, have
you noticed any lasting changes in your beliefs about your own power, having control in your life, in your ability to impact others, and your belief that you can have an impact in the world?

Subject 3 demonstrated a positive lasting change in her beliefs about her own power. She stated,

My sense is yes . . . I've always had some of that . . . . But I think working with a population where that's often the focus, . . . people being able to experience their own sense of power . . . . So it has had an impact, positive, I mean a growth-producing impact for me as well, I'm sure.

Subjects 1 and 2 did not demonstrate a lasting change in their beliefs about their own power. Subject 1 talked about her strong beliefs about her own power, but stated that "I don't think my client population affected that." She stated, "I believe very strongly that I have an ability to change anything I set out to change. And I'm certain that I convey that to my clients." Subject 2 stated, "I think I've gotten more specific about where I have power and more realistic about how much, and how I can use it. But I don't necessarily see it as more or less."

7b. As a result of treating adult female incest survivors, have you noticed any lasting changes in your beliefs that your clients can have power, control in their lives, can impact others and can have an impact in the world?

Subject 3 demonstrated a positive lasting change in her beliefs about power for her clients, indicating that she has noticed an increase in her belief that her clients can have power. She stated,

Yes . . . I know I have that belief . . . always had a belief in that, always worked towards that, always been in some ways a role model for that. And if I think of that in
a continuum . . . I'm probably further than I used to be and in a good place with it . . . the word optimism comes to mind, the sense that people can move on.

Subjects 1 and 2 did not demonstrate a lasting change in their beliefs about their clients' ability to have power. Subject 1 stated, "I just always operate on the assumption that they can." Subject 2 stated, "I've always had a strong belief that they can have an impact on others and a sense of power."

In the area of power, a common response pattern among the three subjects was not apparent. Two of the subjects did not demonstrate lasting change in their beliefs about power for either themselves or their clients. One subject demonstrated positive lasting change in her beliefs about power for both herself and her clients.

Question 8. Intimacy/Connectedness

8a. As a result of your work treating adult female incest survivors have you noticed any lasting changes in your sense of intimacy or feeling connected to others like a partner, colleagues, family or friends and belonging to a larger community?

All three subjects demonstrated lasting change in their sense of intimacy and connectedness. Subject 2 demonstrated positive lasting change for herself, and Subject 3 demonstrated positive and negative lasting change in her beliefs about herself. Subject 1 demonstrated a negative lasting change for herself. Subject 1 talked about the intensity of the therapy with her incest survivor clients, many of whom are "multiples." She stated:

The kind of therapy that you do with multiples is so
intense that sometimes your greatest connections are to them. And you have to struggle to keep that in balance. . . While I don't meet my needs for intimacy through them, it's such powerful and creative work that it could obliterate other connections for a time. . . . It has the potential to seduce someone into a kind of pseudo-intimacy, where your clients are the closest to you.

Subject 1 also talked about the isolating impact of her work at times, and the impact on her connection with her husband and some colleagues. She stated:

When you finish these kind of sessions . . . you need sort of a decompression time, and that then impacts how you connect to your family and to your friends. And at a certain point you leave everybody else behind. I mean you're trying to protect the confidentiality of your client. You may have just heard . . . something that is just beyond your normal experience, and you really can't talk with anyone about that. . . . So you're left alone with that knowledge and that was difficult and isolating. . . . I'm sure it's . . . affected the marriage. . . . My colleagues here in the office know the kinds of things that I work with, but it's not part of their lives, so they . . . aren't able to offer much support. So you have to go and find your support systems where you can, and that's what I did.

Subject 2 demonstrated a positive lasting change in her sense of her own connectedness. She stated,

I would say that has increased— the sense that we're kind of in this together with other therapists, and a real compassion for clients as well as other therapists, a sense of connection. Maybe that sounds odd, but that's what my experience has been.

Subject 3 also reported a lasting change in her sense of intimacy and connectedness. She stated clearly that, "It has made a lasting impact on my beliefs that I can be connected to others. Yeah, I'm certain that it has." However, her narrative did not clearly indicate to either of the readers whether this was in a positive or negative direction. She talked about how shame
interferes with people's ability to experience intimacy, and:

feeling acceptable [sic] enough of themselves in order to maintain and create close relationships. . . . Yes, it has made an impact on that [intimacy], especially in relation to this sense of shame and not--and working through that in whatever way you do about what that means about you as a person. Yes . . . that has had an impact for me as a result of my work in this area.

In a later phone conversation with Subject 3 to clarify the nature and direction of this lasting change for her, she said, "My sense is that it is both positive and negative, but more positive." She stated that intimacy has been a "pervasive" issue in her life, and she has achieved a greater feeling of comfort in her life, "not only in experience with myself, but in general . . . interactions and relationships with people." Based on her interview and later phone clarification, her responses were coded as demonstrating both positive and negative lasting change in her own sense of intimacy and connectedness.

8b. As a result of your work with these clients, have you noticed any lasting changes in your beliefs that your clients can feel intimacy, connected to others and belong to a larger community?

All three subjects demonstrated lasting changes in their beliefs about their clients' abilities for achieving intimacy and connectedness. Subjects 2 and 3 demonstrated a positive lasting change, while Subject 1 demonstrated a negative lasting change. Subject 2 stated,

Yes, we do group work too, and many of our incest survivors are in a group. I would say that their ability to be connected is rather amazing when you see how isolated they have been. So I'd say it's an increased sense of their ability to be connected to others.

Subject 3 stated,
Yeah, I guess in relationships I certainly believe they can... I would say it's grown, strengthened perhaps would be the word over the years, again as probably other awareness and insights have both into myself and the people I work with.

Subject 1 demonstrated a negative lasting change, since she indicated that her beliefs about her clients' ability to achieve intimacy and connectedness with others have moved from an optimistic position to one which realizes the relational consequences of their childhood abuse. She stated,

I think I would have been more optimistic initially, you know--'we'll fix this and everything will be O.K.' And I still believe that things can be O.K., but I have a sense that they will be more brittle... their connections will always be some what impaired, even though I have the expectation for them to be connected much more than when they start therapy. But I think the level of scarring is so significant that they won't ever be connected as I would hope them to be.

In the area of intimacy and connectedness, a common response pattern was apparent in that all three subjects demonstrated lasting changes in their beliefs about intimacy and connectedness for both themselves and their clients as a result of treating adult survivors of incest. Subject 1 demonstrated negative lasting changes for both herself and her clients. Subject 2 demonstrated positive lasting changes for both herself and her clients. Subject 3 demonstrated positive lasting changes in her beliefs about her clients, and both positive and negative lasting changes in her beliefs about herself.

Question 9. Frame of Reference

9. Many people believe in a world which is meaningful, just and fairly predictable as part of their frame of reference. This is a an
example of one frame of reference. Please reflect on your frame of reference. After treating adult female incest survivors for 10 years, have you noticed any lasting changes in your overall frame of reference or your way of making sense of life's experiences?

Subjects 1 and 2 demonstrated a negative lasting change in their frame of reference, while Subject 3 reported no lasting change.

Subject 1 initially said that she has not noticed a lasting change in that "I've always operated on a Christian framework ... [coming from a] fairly liberal, Christian tradition of love, and all that good stuff." She demonstrated a shift in a negative direction when she talked about being more aware of evil, and the senselessness of horrible acts done to clients as children. She stated, "But I think I'm more in touch with evil. . . . I think there are people who choose to behave in evil ways." She conveyed some of her struggle to reconcile "unbelievable things" with her biological model of behavior. She said:

I think at the end of a session where unbelievable things have been shared, part of me will just sort of go, 'Why?' I try to put things back to a biological model . . . what would be adaptive about these kinds of behaviors taking place . . . . Even if I can trace it back and figure out why it happened, it still feels senseless. I get angry, but I don't think my world view has been shaken, except to expand the number of people obviously that are in the world that choose to do evil acts, and to do things I wouldn't have thought could be done [exhales audibly]... I don't ever want to be taken as a hostage, because I now have more understanding of what [she exhales]--how a person could be hurt, and I don't think I did before.

Subject 2 spoke about how treating incest survivors has shaken her frame of reference in a negative direction. She stated:

I've had a strong frame of reference. And working with
incest survivors has shaken it to some extent because these things are so capricious ... just kind of seem to happen and then more bad things happen on top of that. It's discouraging. But it has not really changed my sense that there's meaning in life or that there's an overall benevolent power that looks after us ... But it has made me less simplistic in my ... frame of reference. [She added with slight sarcasm that she did not believe] 'Oh, of course, everything's going to work out for the best' ... justice, you know, is elusive and life is not fair. And that's a very strong belief ... And on the other hand, I don't think we were promised at any point that life was going to be easy or anything like that.

She stated that the shift toward a "less simplistic frame of reference" has resulted in feeling "more isolated" with people who are not exposed to sexual abuse. She stated:

It has made me somewhat impatient with people who have a more simplistic view, and who have [voice stronger] not listened to people the way I have listened. And then they can rather piously talk about how God looks after everyone. ... It does ... make me feel more isolated in my views when I get into a group of people who are less experienced, less exposed to the world of sexual abuse.

She stated that she was more aware of feeling shaken in her frame of reference earlier in her career. She stated,

I would say that's not as obvious now as it was at an earlier point. I think I've kind of come to a different sense and more form in my frame of reference now, after coming through a period of being shaken.

She added, "I don't feel as judgmental by any means as I was at one point in my life." In response to a later question, she said that her work with this population has "really taken away any sense of that this is a loving world ... I still believe that in specific instances, but not in the big picture."

Subject 3 said that working with this population has reinforced her "world view" and does not think it has changed. She laughed at
the interviewer's example of a frame of reference, of a "world which is meaningful, just and fairly predictable." While initially search-
ing for ways to identify her frame of reference, she stated:

It's like 'Shit happens,' that's kind of my world view. It's like [said with an even drawl] 'God, I don't know what doesn't happen!' So the idea that, you know, that life is fair, predictable . . . it doesn't fit. I don't think it ever did . . . I don't think life is real predictable. I think people behave in certain ways and there are certain things you can expect, but again just about anything can happen. And again, if we are talking specifically about people being sexually abused, you know, it happens [she exhales]. It happens a lot more than people would like to believe.

In the area of frame of reference, a common response pattern among the three subjects was not apparent. Two subjects demonstrated negative lasting changes in their frames of reference, while the third subject did not demonstrate lasting change.

Question 10. Significant Others

10. Please reflect on these beliefs as they relate to those you care about, like a partner, friends, or children. Have any of your basic beliefs [related to safety, trust, independence, intimacy and connectedness, power or esteem] about those you care about been changed in lasting ways as a result of treating this client popula-
tion?

All three subjects demonstrated lasting changes in at least one of their beliefs about their significant others. Subjects 1 and 2, who were also parents, demonstrated negative lasting changes in their beliefs about safety for their children. Subject 3, who was not a parent, stated that she has had both positive and negative lasting
changes in some of her beliefs about her significant others.

Both Subjects 1 and 2 identified lasting changes in their beliefs about their children's safety. Subject 1 stated, "I worry about my child's safety more than I would have before." In response to an earlier question about safety, she stated that she was "more aware when my [child] was growing up, not wanting [her child] to walk to school . . . figuring that people would harm [her child] as a way to harm me."

Subject 2 also identified ways that her beliefs that her children can be safe and trusting of others have diminished as a result of treating this population. She stated:

My sense of protectiveness about my children is greater than it would otherwise be. I am much more apt to be talking to them about . . . making sure they aren't molested. . . . I know I'm more that way than my friends are. I am more suspicious of motivations of people towards my children. And when I hear about things they say about their friends . . . I'm not just taking things at face value.

Subject 2 stated that she does not feel that she trusts her husband or children less as a result of treating this population. But she added:

I have very few illusions as far as if someone said, 'My husband has molested someone.' I wouldn't get into orbit about that. I would think, "Well, let's find out about that" . . . because nothing is impossible—because I think otherwise I wouldn't think that way.

Subject 3 stated that her work with this population over the last 10 years has "had some long term effect" on her beliefs in such areas as safety, trust, and esteem for some friends and the children of friends or family members. She said she experiences the change as "an expansion, more sensitivity or different sensitivity, so it feels
positive." She said that she is not "paranoid" about "all in the
children in my life." In a later phone conversation, the interviewer
asked if she could give any specific examples of the "long-term ef-
fect" on her beliefs about her significant others. She said that the
lasting change in her beliefs could be described as both positive and
negative, with more weight toward the positive. She stated:

It's had an impact. And it wasn't necessarily positive or
negative. It's both. Clearly it's had an impact. I guess
overall I would say [it's been] more positive.

She also said:

Certainly they [her significant others] have the ability in
which they can work through this. . . . I can say that in
a real proactive, positive way or I can frame it in the
reality that a lot of people don't reach that level of
functioning, don't reach that level of resolution. That
both are true. I think that overall the reality is that
people can work through that, that people can be safe and
can move in a more positive direction. . . . I do not be-
lieve that is always the case.

In the area of beliefs about significant others, all three
subjects demonstrated lasting changes in some of their beliefs about
their significant others, particularly beliefs about safety. Two of
the subjects, who were also parents, demonstrated negative lasting
changes in their beliefs about the safety of their children. The
other subject indicated experiencing both positive and negative last-
ing changes in her beliefs about safety, trust and esteem for her
significant others.

Clusters of Lasting Change in Cognitive Schemas

In reviewing the above summary and Table 1, it is evident that
there are clusters of lasting change in the cognitive schemas of
Safety, Intimacy and Connectedness and the more general question (Question 10) about lasting changes in beliefs about significant others.

**Cognitive Schema of Safety**

First, lasting changes in the cognitive schemas relating to safety will be explored. A closer examination of the subjects' responses to Question 10 reveals that two of the subjects (1 and 2) demonstrated negative lasting change regarding their beliefs about their children's safety. Subject 3 reported positive and negative lasting change regarding her beliefs about the "safety, trust and esteem" of her significant others. The cluster of lasting change in the area of safety is more apparent when the coded responses in Question 10 having to do with the safety of significant others are grouped with the coded responses to Question 3 (Cognitive Schema of Safety). The codeable units in the cognitive schema of safety have been summarized below in Table 2.

A cluster of negative lasting change in this cognitive schema occurs about beliefs about the safety of significant others. The two subjects who are parents (Subjects 1 and 2) reported a decrease in their beliefs about the safety of their children. Even Subject 3 who was not a parent reported negative lasting change in her beliefs about the safety of children of her friends or family. (She reported positive and negative lasting change in the schemas of safety, trust, and esteem.)
Table 2
Cognitive Schema of Safety

<table>
<thead>
<tr>
<th>Beliefs About</th>
<th>Subject 1</th>
<th>Subject 2</th>
<th>Subject 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>LC-</td>
<td>0</td>
<td>LC+</td>
</tr>
<tr>
<td>Clients</td>
<td>LC+</td>
<td>LC-</td>
<td>LC+</td>
</tr>
<tr>
<td>Significant others</td>
<td>LC-</td>
<td>LC-</td>
<td>LC+ and LC-</td>
</tr>
</tbody>
</table>

LC- = Negative lasting change (Vicarious traumatization)
LC+ = Positive lasting change
0 = No change

Subject 1 demonstrated negative lasting change in her beliefs about her own safety, about her child’s safety, but positive lasting changes in her beliefs about her clients’ safety. Subject 2 demonstrated negative lasting change in her beliefs about her clients’ safety and her children’s safety. According to the conservative criteria employed in the Unique Coding System, she demonstrated no lasting change in her beliefs about her own safety. However, she did report that she feels less safe, but attributes this "to age," although she mentioned that questions about her safety have been brought up to her by working with this population. Subject 3 demonstrated positive lasting change in her beliefs about the safety of herself, her clients, and both positive and negative lasting change in her beliefs about her significant others.

Cognitive Schema of Intimacy/Connectedness

The cluster of lasting change demonstrated by all three subjects
in the cognitive schema of intimacy and connectedness is worth noting. Subjects 2 and 3 demonstrated positive lasting change in their beliefs about intimacy and connectedness for both themselves and their clients. On the other hand, Subject 1 demonstrated negative lasting change for both herself and her clients in this schema.

Reflecting on the differences between Subject 1 compared to Subjects 2 and 3, the following factors in their professional support systems may contribute to the direction of lasting changes in this schema. Subject 1 reported that she works with a very demanding population of incest survivors and has little regular professional support. For example, she reported that 50% of her caseload was comprised of incest survivors also diagnosed with multiple personality disorder. While she reported intensive weekly training and consultation on treating these clients earlier in her career, she indicated that she currently has supervision "as needed." She reported having "informal consultation" with a female colleague in another practice. On the other hand, Subjects 2 and 3 suggested they may treat a smaller number of MPD clients, and they both received regular consultation with female colleagues in their practices as well as regular supervision on all their clients. They both stressed the importance for them of regular supervision on all their clients as well as peer consultation. Subject 2 specifically mentioned that treating this population has increased her "sense that we're kind of in this together with other therapists." Both Subjects 2 and 3 also co-lead client groups, which include many incest survivors. Co-leading a group with another colleague may also enhance their sense of
connectedness, as well as enhance their beliefs that their clients are capable of connectedness as a result of what happens in the group experience. It appears that Subject 1 operates with very little support, supervision, or consultation. She works primarily alone with a demanding group of clients. Subjects 2 and 3 have professional support systems in their respective practices, which include supervision, consultation with female colleagues, and delivery of service (group) with another colleague.

It may be that having regular professional support allows the therapist to process traumatic material and review complicated treatment issues with others who understand. And in the face of sometimes overwhelming traumatic material, it may help her maintain, or even increase, her beliefs in her ability to connect to colleagues, family, friends, and belong to a larger community. Judith Herman (1992) has suggested that without a professional support system, a therapist may become more isolated and disconnected from colleagues:

> no one can face trauma alone [author's emphasis]. If the therapist finds herself isolated in her professional practice, she should discontinue working with traumatized patients until she has secured an adequate support system. .

.. The role of a professional support system is not simply to focus on the tasks of treatment but also to remind the therapist of her own realistic limits and to insist that she take as good care of herself as she does of others. (p. 153)

Earlier she stated,

> Unless the therapist is able to find others who understand and support her work, she will eventually find her world narrowing, leaving her alone with the patient. The therapist may come to feel that she is the only one who really understands the patient, and she may become arrogant and adversarial with skeptical colleagues. As she feels increasingly isolated and helpless, the temptations of either
grandiose action or flight become irresistible. (Herman, 1992, pp. 152-153)

Evidence of Vicarious Traumatization

Examining the data for evidence of vicarious traumatization reveals that all the subjects demonstrated negative change in their beliefs which have persisted for a year or more in one or more of their cognitive schemas as a result of treating this client population. These negative lasting changes correspond to the examples cited by McCann and Pearlman (1990b) as evidence of a vicarious traumatization process in the seven cognitive schema (See Appendix E, Unique Coding System). In some instances subjects described these negative lasting changes as being disruptive and painful (McCann & Pearlman, 1990b) for them, especially earlier in their careers.

Cognitive Schemas Demonstrating Vicarious Traumatization. A review of the negative lasting change in the subjects' cognitive schemas revealed that two out of three subjects experienced negative lasting change as a result of a vicarious traumatization process, in each of the following beliefs: about their trust of others (Subjects 2 and 3) about the safety of their children (Subjects 1 and 2), and their frame of reference (Subjects 1 and 2). One subject demonstrated negative lasting change in each of the following beliefs about self: safety (Subject 1), intimacy and connectedness (Subject 1), esteem—that others are benevolent and worthy of respect (Subject 2).

It is interesting that all these cognitive schemas in which
negative lasting change was demonstrated about self or their children involve beliefs about self in a dependent relation to others who may be dangerous (safety), untrustworthy (trust), and lacking in understanding and empathy (intimacy and connectedness). It is also interesting that there was no negative lasting change reported in the cognitive schemas of independence and power. McCann and Pearlman's (1990a, 1990b) definitions of the cognitive schemas of independence and power seem more weighted toward the action of the self on others or the world rather than a person depending on others for their well-being. For example, McCann and Pearlman (1990a) define independence as "freedom, independence and the ability to make your own choices" (p. 23), and power is defined as "having control in your life, the ability to impact others and have an impact in the world" (p. 23). Contrast this with their definitions of safety as "feeling safe or reasonably invulnerable to harm [from others seems to be implied]" (p. 23), and trust as "believing what others tell you, trusting others and depending on them to meet your needs" (p. 23). The data suggests that the cognitive schema having to do with the self depending on others for safety or trust, for example, may be more prone to negative lasting change, or a process of vicarious traumatization, than those schemas having to do with the individual's action on others and the world.

Subjects Demonstrating Greater Frequency of Vicarious Traumatization. Each of the three subjects demonstrated one or more negative lasting changes resulting from a process of vicarious traumatization,
in the seven cognitive schemas in beliefs about themselves. Table 3 summarizes the schemas in which negative lasting change was demonstrated among the three subjects.

There is no apparent pattern of negative lasting change across all three subjects. McCann and Pearlman (1990b) hypothesize that how the trauma is processed depends in part on which schemas are most prominent (or salient) for that individual. For example, the narrative of Subject 3 gives some support for this hypothesis. She stated that "fear" and "shame" have been issues in her life. One might hypothesize that the cognitive schemas of safety, trust and intimacy/connectedness have had more salience for her. She demonstrated negative lasting change in the cognitive schema of trust/dependency, and demonstrated positive lasting change in safety and intimacy/connectedness, which she credited to working with this population which she said was growth producing, and her own therapy. This may suggest that although a schema may have particular salience for an individual, many factors influencing how the individual processes the traumatic material may result in lasting change in that schema which may be positive or negative. These factors could include the psycho-social history of the individual, personality style, the use of a professional support system, the type of traumatic material shared by clients, the percentage of clients who are severely dissociative, such as MPD clients, and the use of personal therapy.

When comparing the incidence of negative lasting change in cognitive schemas between subjects (see Table 3), one notices that Subjects 1 and 2 have demonstrated negative lasting change in three
Table 3
Vicarious Traumatization in Cognitive Schemas About Self

<table>
<thead>
<tr>
<th>Cognitive Schemas</th>
<th>Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Safety (LC- = Negative lasting change)</td>
<td>LC-</td>
</tr>
<tr>
<td>Trust/Dependency (LC- = LC-)</td>
<td>0</td>
</tr>
<tr>
<td>Esteem-2. Others are benevolent (LC- = 0)</td>
<td>0</td>
</tr>
<tr>
<td>Intimacy/Connectedness (LC- = LC+)</td>
<td>LC-</td>
</tr>
<tr>
<td>Frame of Reference (LC- = LC-)</td>
<td>LC-</td>
</tr>
</tbody>
</table>

LC- = Negative lasting change (Vicarious traumatization)
LC+ = Positive lasting change
0 = No change

cognitive schemas, while Subject 3 demonstrated negative lasting change in only one. Subjects 1 and 2 stated that work with this population has shaken their frames of references, especially earlier in their careers. They both demonstrated that their frames of reference have been changed in a negative direction. On the other hand, Subject 3 stated that she began her career with a rather sober, down-to-earth frame of reference, namely, "Shit happens." In addition to the factors mentioned above, the amount and direction of lasting change in a therapist's cognitive schemas certainly depends on the original nature of one's beliefs in particular cognitive schemas. For example, if one originally has very optimistic or "pollyanna" schemas or beliefs, one might expect negative lasting change as a
result of treating this population over time. If one originally has sober or even cynical beliefs, one might expect no change or even lasting change in a positive direction as a result of seeing many examples of client growth.

Analysis of General Questions

It was judged valuable to allow the subjects an opportunity to comment on aspects of their experience treating this population by way of a variety of general questions. Some of these questions allowed subjects latitude to respond from their own frame or theoretical viewpoint. The following is a summary of the themes within each question, with supportive quotations from the subjects' narratives.

Question 1

As you listen to the stories of adult female incest survivors, what feelings and reactions do you usually have?

After their 10 years experience treating adult female incest survivors, all three subjects said they continued to be deeply touched by the stories of these clients, but also were seasoned to dealing with it. "It still can still touch me very deeply, but I'm not shocked. ... So I'm desensitized to it" (Subject 1). "I'm very seasoned about what I listen to, so I'm not prone to being knocked off my seat" (Subject 3). Subject 2 added that dealing with how much clients will suffer during the therapy process "is not easier as it goes on. Actually, the more I know, the more I kind of
feel the anticipation, the pain of it." Later in the interview Subject 1 also suggested that having 10 years of experience does not make the work any easier emotionally.

Two of the subjects (1 and 3) specifically mentioned feeling anger and rage in response to the stories they hear. Subject 2 said that she sometimes feels a kind of "bracing myself" to help her focus on a client's experience, and with that "a bit of dread because I, I just know so much of what it's going to be like, and how much I'm going to see that person suffer." Subject 3 said that she often feels "sadness for what people's feelings have been." Subject 2 also said that she feels "very respectful of what they have survived... amazed at their ways of coping... humbled in response to what they have gone through."

Question 2a

After your 10 years experience with these clients, are there any aspects of treating adult female incest survivors that you find personally demanding?

All three subjects stated that they found aspects of treating this population to be demanding. Subject 1 stated that she found "every part of it demanding." Subjects 1 and 2 stated that it is demanding to be authentic and present with survivors who are working through the aftereffects of sexual abuse. Subject 2 stated,

It's this whole business of just being right with them, is demanding and draining... the more you can stay with them and still stay objective, that is a big effort. And when you get done with a session like that, you really need to go and divert yourself or do something different.
Subjects 1 and 3 stated that dealing with clients' suicidal behavior and homicidal feelings is also very demanding. Subject 1 stated, "You are constantly responding to suicidal or homicidal feelings that put the therapeutic alliance at risk. So it's very complicated work."

The three subjects also mentioned these other aspects of treating this population that are demanding: dealing with dissociation and self-abusive behavior (Subject 3), being positioned to recapitulate the client's abuse (Subject 1), dealing with client crises on weekends or other times outside the therapy (Subject 2).

Subject 1 commented about the demanding features of treating MPD incest survivors, who comprise about 50% of her caseload. She said:

You must be 100% authentic and in the moment always. . . . Every second, every nuance of the session is being attended to by a cast of thousands [she laughs]. When I'm dealing with multiples . . . you're sort of on stage--you can't be phony in anyway. They're looking for any sign of betrayal.

Question 2b

If you think back to when you first began treating these clients, were there any aspects of treating adult female incest survivors that you found personally demanding for you then?

When they first began treating this population, all of the subjects said that in many ways they were not prepared to deal with aspects of treating survivors of incest. Two of the subjects (1 and 3) experienced some distress when first beginning to treat this population. Subject 1 said that treating this population, which in her
experience included many clients with MPD, was very demanding "because back then I didn't know what the hell I was doing! . . . And so it was responding to incredible pain and drama early on, with a limited number of tools." Subject 3 stated that "You know, I was green back then . . . and this was a particularly challenging area to work." She also said that she found treating adult female incest survivors "overwhelming" because she grappled with her own disbelief, her "ability to absorb and not carry [the stories] with you and how horrendous that can be, as well as challenging your beliefs about goodness." Subject 2 said, "I think when I first began treating this population, I was quite naive, and hadn't been completely tuned in to this issue. . . . And so I don't think there were aspects then that were draining." She stated that her outpatient therapy experience with this population unfolded gradually under good supervision, and so she did not find her early experiences with this population personally demanding.

Question 2c

Do you find that there is anything unique in treating this client population compared to other populations that you have worked with?

All three subjects addressed the difficulties these clients have in maintaining relationships, as well as the challenges this offers the therapist for working in the therapy relationship. Subject 2 stated:

This is the least trusting population that I've ever dealt
with. And it's interesting how you establish a relationship, it's usually a fairly long process of therapy and over that time period you keep establishing deeper and deeper levels of trust, which I don't think is as common with other kinds of clients, that you have to attend to that so much.

Subject 3 commented that depending on the duration of the abuse and age of the client at onset, "we're looking at the most disruption in terms of boundaries and the ability to maintain relationships, and the other developmental tasks that were interrupted." She said that such issues as "boundaries, relationships to others, tolerance for intimacy and connectedness" are unique in treating this population.

Subject 1 discussed ways that the issues of boundaries in the therapeutic alliance are more prominent in treating this population. She stated:

... boundaries both in terms of establishing them and setting them, but also in breaking them in ways that I would not routinely have thought would be O.K. in the therapy process. That it is both the ability to maintain boundaries that the client knows you will keep and you won't violate, and at the same time to disclose in ways you might not disclose otherwise, or reach out with acts of kindness that you might not have otherwise done, that humanize their experience for them. ... And being available outside of the therapeutic hour is probably--I don't do therapy by phone, but people are so fragile as they move against all their old ways of thinking that they need opportunities to connect with the therapist other than the therapeutic hour. And so you have lots of intrusions into your family time, or your weekend time which you have to figure out how to manage or learn to extend.

Subject 1 also added that issues of countertransference and transference are more prominent with this population than with other clients in her practice. Subjects 2 and 3 also addressed some of the unique transference and countertransference issues with this population in their responses to Question 14.
Question 11

In your 10 years of experience treating this population you've probably had numerous powerful experiences. Have you had any especially powerful or striking experiences in treating adult female incest survivors that come to mind that you wish to talk about?

In response to this question all three subjects chose not to talk about specific experiences, but rather to respond in more general ways. Subject 1 found the question to be too broad. She chose to talk about the use of "non-sexual" touch with clients which "is very much a product of this work" and has developed since she began treating this population 10 years ago. She commented:

If I were not a female therapist working with female clients I'm not sure that touch could be utilized in the same kind of way... And having to respond to internal children who have been hurt has led me to find ways to safely touch my clients, to hold them, to rock them, to hug them, you know, to--any number of ways of non-sexual touching are very powerful moments that I think would not come out of traditional therapy; [with emphasis] does not come out of traditional therapy, and has a healing aspect for the women, to experience safe touch.

Subject 2 said that her experiences with clients are not the kind of thing that she likes to talk about. She stated that "I've got some experiences that could just wow the socks off anybody, you know, of what it was like to be with this multiple personality when one of her satanic alters was there. [Said matter of factly.] Frankly, I was quite frightened." She said that she finds it frustrating when she gets into some depth work with a client, and finds how little a client trusts her, and has to work with the client to increase awareness of what the client is doing.
She focused on a "very powerful experience" she has had with many different clients. She said that many of her clients come in with a very competent presentation, and they may be "on top of things" in their professions. She said that she experiences an "incredible contrast" when they begin talking about their abuse history. She said that their faces "crumble," conveying how frightened, shamed, and often very attuned to whether the therapist will be angry with them, or repulsed by them, as the clients are by their own memories. As Subject 2 related her experience, her own face "crum­bled" as she began to cry openly. Although she seemed all right with her tears, she interjected that "I don't talk about it much. And I don't cry about it with them [clients], believe me, I don't!" She added that she has become very "respectful" when talking to a client in her "competent mode," remembering "that there is this other part."

It seemed that Subject 2 may have been reenacting with the interviewer what she experienced with her clients. She later acknowledged that such experiences with clients move her very deeply. It appeared that she was also expressing some of her own sensitivity and vulnerability to the emotional demands of treating this population.

Subject 3 stated that she does not have any "dramatic stories that come to my mind of quick cures or people who have gone on to do some phenomenal thing." She reflected generally about clients who have made significant changes in their lives, in terms of making "an impact on the safety of their own children in terms of breaking the cycle of abuse." She also reflected with sadness on clients who left therapy who seemed to be stuck or for whom the abuse "never seems to
be over." She found that her work with "a lot of people over the years has made an impact in their lives... It hasn't always gotten them to the end of the process, ... but usually it's had some impact."

**Question 12**

Have you noticed that treating adult female incest survivors ever prompts any strong physical reactions in you?

All three subjects mentioned some physical reactions that they have had or continue to have in treating this population. The one common physical response among the subjects was stomach reactions. Subject 3 mentioned feeling nauseous at times, and Subject 2 mentioned a "queasy" stomach associated with some anxiety when she senses a client "beginning to go into something." Subject 1 mentioned that earlier in her experience in response to an account of ritual abuse, feeling "shaky," but "not throwing up."

They all reported their physical reactions in straightforward ways and as part of their process that they have learned to manage. No one elaborated on their responses or seemed distressed by them. Subject 1 stated that "the strongest physiological response that I have is rage, and all of the things that go with rage." Subject 2 stated that she does not have strong physical reactions. Subject 3 stated that she has experienced "crying," "short-term trouble sleeping," feeling "frightened," and feeling angry with the urge to punch someone.
**Question 13**

Have you noticed that treating this population ever influences your dreams or daytime images?

Two of the subjects said that treating this population has influenced their dreams and the third believed it has affected her daytime images. Subjects 1 and 3 both said that treating these clients prompted dreams earlier in their career. Subject 1 remembered having "scary dreams" of her personal safety and for her child's safety. She said these have diminished with time. Subject 3 said that she does not typically remember her dreams, but especially earlier in her career she could remember dreaming about a few clients, and one incest survivor in particular. Subject 2 said that treating this population has not influenced her dreams. She said, however, that her daytime images have become more numerous, and she uses this as a way of promoting the therapy. She believed that treating this population has stimulated her imaging ability, but stated that she does not have images outside of therapy of what survivors have shared with her in therapy.

**Question 14**

Have you noticed that these clients position you or place you psychologically in any particular roles?

All subjects agreed that these clients position them psychologically in particular roles, and dealing with this positioning is an important part of the treatment. Subject 1 said that each of the
roles "has to be dealt with directly . . . and real openly." Subject 2 stated that "it is a very important part of treatment to use whatever you can to understand how they are experiencing you." Subject 3 said that she views these roles as "all part of the transference," and that "it's helpful if you can be aware of that and deal with it therapeutically." She said that she expects it as part of therapy. The three subjects gave different examples of how they deal with such positioning. Subject 1 gave two examples of how she has confronted and worked with different roles. Subject 2 talked about dealing with being placed in the role of the "all-giving one," but allowing the client this transference for a time as she builds "some growing sense that there is someone giving and caring." Subject 3 suggested that she too may "stay with it" or "confront" various roles or transferences, depending on what is best needed therapeutically.

They all talked about being positioned in the role of "perpetrator or abuser." Subject 1 stated that her clients assume "I'm just another perpetrator, and it's just a question of time till they figure how I'm going to hurt them." She related a recent experience in which a client positioned her as a kind of perpetrator by placing her in the position of having to break confidentiality in response to the client's suicidal threat. She reported the rage this triggered in her, how she contained it and how she used some of her anger to confront the client on what she was doing. Subject 2 reported that a client recently positioned her as the "abuser." She said that she was aware of the dynamics, "did not feel attacked," and said that exploring this with the client was "very productive." Subject 3
said that she finds that it is demanding to be placed in the role of perpetrator.

All three subjects reported frequently being placed in types of parental roles like being positioned as "Mom" (Subject 1), the all-giving one" (Subject 2), or the "saving or nurturing parent" (Subject 3). Subject 3 said that being positioned as the "saving parent" or the "continually nurturing parent" is "draining after awhile," and more demanding for her than the role of perpetrator.

The subjects mentioned, but did not elaborate on, the following additional roles: "lover and friend" (Subject 1); the "ungiving one" (Subject 2); the "passive or unsolved parent," and the "enabler," (Subject 3).

**Question 15a**

What are the most effective ways that you use to help you deal with the challenges of treating this client population.? I would like to hear about any professional and personal ways that you wish to share.

As the subjects discussed a number of professional methods they use to deal with the challenges of treating this population, they all mentioned the use of peer support and consultation with peers. Subject 1 said that she has shared powerful or disturbing material with a female colleague in another practice, especially earlier in her treatment experience. She said she continues to share aspects of treatment of her clients with this colleague. She stated that "we've had a real good opportunity to learn and grow and support each
Subject 2 stated that it is "essential" to have peers with whom one can review cases. She said it is very helpful, knowing other therapists well enough, being open to them, telling them your doubts about yourself, and having them be able to comment and know you well enough to say, 'Yeah, I think you were off base there,' and having that be O.K.

She stated that she has a very strong relationship with a female colleague in her practice which she finds helpful. Subject 3 also mentioned consultation with other therapists treating similar cases as a professional way of taking care of oneself. She noted that this is a general way she takes care of herself and not specific to working with this population.

Two subjects also discussed the importance of supervision and training. Subjects 2 and 3 stated that having supervision is important. Subject 2 said that she has always had supervision for all her clients, not just adult incest survivors, and Subject 3 also stated that supervision is a general way she takes care of herself as a therapist. Subjects 1 and 3 mentioned training as a way of preparing oneself for treating this population. Subject 1 said she has participated in conferences dealing with multiple personality disorder as well as seeking weekly training in another city. Subject 3 said that she probably attended more workshops and conferences earlier in her career.

Subjects 2 and 3 talked about the importance of setting clear limits and clear personal boundaries when treating this population. Subject 2 stated that one should have:

your own sense of personal boundaries so that you do not become in some way the person who is just going to give,
give, give and be completely drained. I think it is crucial to have a guarded way that people can get in touch with you, not just have them free to just interrupt your life at any point. I disagree with therapists who give people their home phone numbers.

Subject 3 stated that she is "pretty good in and pretty clear in setting limits with people about how much I can do. I'm thinking about calls and dealing with emergencies and that kind of stuff."

The subjects mentioned a variety of ways they take care of themselves personally as they deal with the challenges of treating adult female survivors of incest. Subject 2 stressed the importance of having a balance in her life, including many involvements that offer a lot of contrast to sexual abuse, including choosing entertainment which is "just fun." Subject 1 said she tries to achieve a balance in her life, but describes herself as a "workaholic," and rates her success as average. She said that she tries to balance her work with time with her family and tries "to play."

A variety of other ways of dealing with the challenges of treating this population were mentioned including: one's own therapy (Subject 3), gardening (Subject 1), tending to plants in one's office (Subject 2), vacationing regularly (Subject 3), and taking hot baths (Subject 1).

**Question 15b**

[An additional probe asked of Subjects 2 and 3]. If you think about a new therapist beginning to treat this client population, what suggestions do you have for such therapists, both professionally and personally?
Subject 2 said that she has given a lot of thought to this question. She stressed the importance of having good personal boundaries, personal self-examination, having been in therapy oneself, and having experience with other populations. With some intensity she stated:

I'm just appalled at the way people don't keep their own personal boundaries with sexual abuse survivors. [They] reach out and try to fix it for them, and all of this. And I understand this is a very common problem when people are new. . . . There are so many people who can try and work with these people and just go under or be completely not helpful.

In response to a later question [No. 17] she commented:

Don't think that just because you've gone to grad school you are qualified to deal with this population, you know. You better have done some real self-examination, and I would hope would have some experience with other kinds of clients. Not just everybody can jump in and deal with this group. And you better well have been in therapy yourself, and know what your situation is. I think it's appalling how many people will just open up this deal, open up people's pain and then not have the slightest idea of how to deal with it. . . . they [the clients] do not deserve to be abused again in their therapy. And it hasn't always been sexual abuse, but just plain not being heard by their therapist.

Subject 3 suggested that new therapists should "keep themselves in supervision," and pay attention to the "basic principles of countertransference and transference, what their own experience has been and how it affects their work."

Subject 3 also emphasized the importance of new therapists being aware of "the issues of developmental stages and the effects of abuse on the various developmental stages." She also stressed that it is important for "anyone starting out" to be knowledgeable about character disorders, to be "grounded in characterological effects and what
dynamics to be looking for," to be aware of the level of impairment, and what "characterological symptoms to be looking for." This knowledge can enable therapists to know what to expect and make some predictions. She suggested that without this background new therapists may be "thrown for a loop."

**Question 16**

Do you believe there is any relationship between being a female and the particular impact treating this population has on you?

All three subjects agreed that being a female therapist gave them many advantages in treating female survivors of incest. They suggested that being a female gave them greater awareness of women's vulnerability and ways females may be abused in society. Subjects 1 and 2 said that they are better at treating this population because they are women. For example, Subject 2 confidently stated that "I am better at this work because I am a female." She suggested this came in part from her experience as a woman and resulting awareness of how women "may be taken advantage of in relationships." She also stated that as a female she already has "an innate sense of vulnerability that men don't necessarily have." She said "men do not think about 'I better not walk through that dark parking garage.'" Subject 1 maintained that as a woman she has an "intuitive" advantage over male colleagues. She stated:

But I don't think they [male therapists] intuitively know how to do some of the things we know how to do... I don't think they can understand the meaning of the sexual violation. Cause I think men violate women all day every day in ways that they have no awareness. And so they do
not understand the violations and the meanings of the violations, except in the abstract.

Subject 3 talked about the "identification . . . between female clients and female therapists in the sense that it's a pretty known fact that woman are more vulnerable . . . or more likely to be."

Subjects 2 and 3 stated that part of the advantage comes from being a different gender than the client's perpetrator, who is usually male. (Subject 1 stated that most of her clients had both male and female perpetrators.) Subject 2 stated that since most of her clients were abused by male perpetrators, being a woman "gives me a little step up." Subject 3 stated that:

I think the reality is that the majority of perpetrators are male. . . . So I think that's a dynamic in and of itself that usually you are not the same gender as the person who has sexually abused the person, and that has it's implications.

Subject 3 believed that initially in treatment female clients will feel safer with a female therapist than with a male, and she added "that it is helpful for them to work with a male [therapist] at some point in some part of their process."

Subject 2 also suggested that being a female helped her effectiveness with some of her incest survivors who also "have been abused in therapy relationships with male therapists." She stated emphatically "then I don't think they have a prayer of healing from that," unless they work with a female therapist who is "not necessarily going to be interested in them sexually. That is . . . a calming thing for them."

Subject 2 also believed that "women in general [are] more able
to access their own feelings and use them to help others." And she added, "But I think well trained male therapists are very good at that."

Subject 3 reflected on additional gender implications for herself as a female therapist. She said she is often the same gender as "the passive parent who did not protect." She said this often involves "dealing with their anger towards that parent that you represent." She has found that dealing with client's anger and rage is "a challenge."

Subject 3 stated that she has also found it a "particular challenge when the abuser has been a female" resulting in quite a different transference. She found such a transference was "sticky," and was harder to deal with. She stated that it is "not a comfortable position to be in by any means." She added that she expects transference regardless of the gender mix and expects that she needs to deal with it as an essential part of therapy.

Question 17

Is there anything else in your work with this population you wish to talk about?

The subjects discussed a variety of issues that they found relevant in treating this population. Subjects 1 and 2 focused on issues of justice for their clients, and in doing so revealed some of their own anger about the abuses perpetrated on their clients. While Subject 3 did not focus on justice, she stressed the importance of dealing with client's anger and rage as an important therapist issue.
Subject 1 stated that the issue of justice is important and added:

I recognize that I'm not a policeman. That's not my role. And I say that very clearly to my clients. And I have the sense that most of my clients' perpetrators will have gotten away with it, and will never experience any societal consequences for unspeakable acts. And that angers me tremendously. I just hope there is a hell and they burn there forever. [she laughs]

Subject 2 stated that the issue of how clients can "protest the abuse that was laid on them" needs attention. She also stated that she would like to see "a more clearly defined way for them to protest abuse by therapists." She said that she has a number of incest survivors among her clients who have also been subsequently abused by former therapists. She said that she would like to see ways that the "statute of limitations doesn't run out and they [clients] find out 'I should have gone to this board and complained' and this kind of thing." She stated:

This makes me very angry that there are still male therapists in this town who have abused clients and they're still working. And I want to get a sense of real Oomph behind my clients, not that I want them to go out and sue their abusers. I don't mean that. I just mean to have a powerful sense [strikes her hand on the desk as she says this] of the protest that they can make.

Subject 3 stated that it is important to attend to the client's anger and rage:

I think people are furious who have been sexually abused on some level. I mean they're hurt, and you know, there's obviously a range of emotions, and I'm not . . . focused on anger, but I think that's often a more difficult one for therapists to deal with, again depending on the transfer-ence etcetera, that can be more complicated.

Subject 3 discussed a number of other issues she finds important when treating adult female incest survivors. She said that dealing
with client's dissociation and "diagnosis of multiplicity is difficult--when people are and aren't MPD" She stated, "I don't know of a sexual abuse survivor that doesn't dissociate to some extent." She added that she has some conflict about the full-blown diagnosis of MPD I think it's like [the diagnosis of] 'borderline' in the sense that it's gotten a little overused. I think the true MPD folks are probably not as many as we might recently be thinking there are.

She stated that how one works with alters or parts is very complicated, including the matter of whether one uses hypnosis and trance work.

Subject 3 also mentioned that the use of touch, "safe touch," is a "big question." She said she feels it needs to be dealt with carefully, that she has some "steadfast rules" and "strict guidelines" for herself, which continue to be challenged by these clients. She also mentioned the following additional issues: the defense structures of clients, including use of dissociation, which protect clients from remembering what happened to them; ritualistic abuse and how prevalent it is; when a therapist chooses to work with a client's partner; whether survivors should confront their perpetrators. She concluded by saying that treating this population involves "a lot of challenges," and emphasized again that "boundaries are very, very critical to this work."

Question 18

How has it been for you to answer these questions?

The subjects reported that the questions were interesting and
were less intrusive than they expected. Subject 1 stated that the questions were "pretty easy." She said she expected the interview to include "hard questions" on the impact on the therapist's sex life. She stated, "I would have thought that would be the first question out of the shoot." She elaborated:

If you hear about horrendous things done to a person sexually . . . how does it change your sexual fantasies, how does it change your sexual connectedness? . . . I haven't yet seen any research about the effects of working in this arena on sexual function. I think it has direct relevance.

Subject 2 stated that she likes to answer such "question type" activities because it stimulates her own thinking. She stated that she was not "in the least bit alarmed by anything." She found the questions relevant and worthwhile. She believed that such questions would encourage people "to be thoughtful about their work."

Subject 3 stated that she found the questions "thought provoking." She said that from the researcher's introductory comments about not needing to answer certain questions, she expected to be asked questions about a subject's "own life experience," including whether they were abused themselves. She said this question is "pertinent," and that clients often ask about the abuse history of the therapist.

The subjects' responses to this question suggest the following topics for future exploration: an exploration of the impact of treating this client population on the therapist's sexual function; and an exploration of lasting change in cognitive schemas of therapists with and without sexual abuse in their histories. Inclusion of questions about these topics in this study was prohibited by the
Relational Impact on Female Therapists

The three subjects identify many of the demanding features of treating this population, the impact the work has on them, and the ways they take care of themselves personally and professionally. By way of a summary, some of the unique relational features of treating this population discussed by the subjects in the general questions just explored will be highlighted in the discussion which follows.

All of the subjects attest to the demands and therapeutic complexities involved in treating adult female survivors of incest. From their own vantage points they have identified the following challenging relational features of treating this population: the lack of trust and difficulties maintaining relationships which often characterizes these clients, the boundary issues for these clients and ways this impacts the therapy relationship, the psychological positioning of the therapist by incest survivors, gender issues in the therapy relationship, and the range of therapist responses prompted by this population. Each of these will be briefly summarized.

The subjects addressed the difficulties these clients have in maintaining relationships and the resulting challenges for the therapist in working in the therapy relationship. One subject said that this is the "least trusting population that I've ever dealt with," and that dealing with the lack of trust continues to impact the therapy relationship throughout the course of treatment. Another subject
said that depending on the duration of the abuse and age at onset, the therapists may be dealing with "the most disruption" in developmental tasks, boundaries, and the ability to maintain relationships. The subjects said that their incest survivor client population includes women who may manifest various levels of dissociation, including multiple personality disorder; are often prone to self-abusive behavior as well as suicidal and homicidal feelings; and may meet the criteria of various characterological disorders including borderline personality disorder. These client behaviors have been cited as some of the most challenging for therapists (Guy, 1987).

All the subjects addressed the difficulties their clients have with boundaries and some of the challenges these boundary issues present in the therapy relationship. Subjects 2 and 3 addressed the importance of having clear, personal boundaries with clients regarding such issues as contacting the therapist after hours, and what the therapist's limits are in the therapy relationship. Subject 1 also addressed the boundary issue, but suggested that in her work with MPD clients she finds it necessary to both maintain some boundaries that the client knows the therapist will not violate, but breaks some boundaries she "would not have thought would be O.K. in the therapy process." As examples of this breaking of boundaries, she mentioned being more available outside of the therapeutic hour, involving more "intrusions into your family time," as well as acts of kindness within the therapy, like having a birthday party for the client.

Another boundary issue involves the use of "safe touch."
Subject 3 mentioned that this is a "big question," which "needs to be dealt with carefully." She said that she does not use touch with her clients frequently, and has some "strict guidelines" for herself, which continue to be challenged by these clients. On the other hand, Subject 1 said that over the last 10 years working with this population she has developed a way of using "non-sexual touch" with clients. She recognized that this does not come from "traditional therapy," but "has a healing aspect for women to experience safe touch."

The subjects addressed the psychological roles in which their clients place them in the therapeutic relationship. They all mentioned being placed in the role of "perpetrator or abuser," as well as a variety of parental roles. As they explored the variety of ways they may deal with such positioning or transferences, the range of responses to such positioning included finding such roles demanding and draining, expecting such transferences as part of the therapy, and expecting such transferences to trigger strong countertransferences such as anger and rage.

The subjects identified some interesting gender dynamics of female therapists treating female incest survivors. The subjects readily identified the following advantages of being a female therapist treating this population: having a greater awareness of women's vulnerability to abuse in society and the resulting identification between female clients and therapist, often being a different gender than the client's perpetrator who was most often a male, and as a woman being better able to access and utilize feelings in the
therapy. On the other hand, one subject addressed the challenges and discomfort of being the same gender as "the passive parent who did not protect," as well as a female perpetrator.

The subjects testify to the range of powerful responses prompted by treating this client population, including affective and physical responses, as well as responses in their day-time images and dreams. The most prominent seem to be the range of affective responses reported by the subjects. Although they all suggested that they are well seasoned by their 10 years of experience treating this population, this does not make the work easier emotionally, and they continue to be deeply touched by client stories and their pain. Anger and rage were the most frequently mentioned affective responses. The subjects mentioned feeling anger in response to client stories and in response to some client transferences. Two of the subjects revealed some of the intensity of their anger as they addressed the need for societal justice for their clients with parental perpetrators as well as former therapists who also have abused them. The other subject said that it is important to deal with client anger, and this is often a complicated transference issue for therapists to deal with.

The subjects also revealed the following affective responses to working with this client population: feeling "dread" and anticipation about how much the client will suffer during the course of therapy; feeling frightened at times by client material; feeling more "paranoid, with concerns about personal safety;" feeling concerned about their children's safety; feeling isolated from colleagues and family; feeling sadness for clients; feeling very respectful of what
they have survived, amazed at their ways of coping and humbled in response to what they have gone through. They imply that it is emotionally demanding to be authentic and present with clients as they deal with the aftereffects of incest.

The most common physical responses to treating this population were stomach reactions, including nausea and feeling shaky. Other responses were crying, and the physical sensations that accompany rage. Two subjects reported that treating this population influenced their dreams, with some scary dreams, especially earlier in their careers, and one reported a greater daytime imaging ability as a result of treating this population.

Research Questions

This study was designed to provide responses to the following research questions. The findings of the study will be summarized in response to each research question.

Question 1

What are the most commonly reported responses of experienced female outpatient therapists to treating adult female incest survivors?

The three female subjects in this study who all had an M.S.W. education and 10 years of treating adult female incest survivors in outpatient settings reported the following affective, cognitive, physical, and imagery responses. The most commonly reported affective responses were feelings of anger and rage. The subjects talked
about anger and rage in response to client stories, often targeted at clients' perpetrators (both parents and former therapists). Subject 1 reported feeling anger in response to a specific experience of client transferences and being manipulated by a client, as well as feeling anger when a male colleague did not understand her work with this population. Anger was evident in some generalized ways when the subjects talked about the following: the need for justice for their clients (Subject 1 and 2); and how it is "appalling" when some therapists are not prepared to deal with this population and do harm in the process (Subject 2). One subject also conveyed some generalized anger at men (Subject 1) and another conveyed anger at the prevalence of incest (Subject 3). In spite of being seasoned by their 10 years of experience, they said that they continue to be deeply touched by their clients and their pain, and continue to find the work difficult emotionally.

The most commonly reported cognitive responses included both positive and negative lasting changes in the subjects' beliefs in the areas of safety and intimacy/connectedness. In the area of safety, subjects reported both positive and negative lasting changes in safety for themselves, their clients and their significant others. They also reported both positive and negative lasting changes in their beliefs in the area of intimacy and connectedness for both themselves and their clients.

The most common physical responses to treating this population were stomach reactions, including nausea and feeling shaky, which were specific responses to client memories or a client alter...
personality, with MPD diagnosed clients. Other responses were crying, and the physical sensations that accompany rage. Two subjects reported that treating this population influenced their dreams, with some scary dreams especially earlier in their careers, and one reported a greater daytime imaging ability as a result of treating this population.

Question 2

What do female outpatient therapists with over 8 years experience report as being the most demanding aspects of treating adult female incest survivors?

All with 10 years experience, the three subjects reported the following relational features of treating this population to be most demanding. The early damage to these clients' ability to trust, with resulting disruption of developmental tasks, boundaries and ability to maintain relationships offers complicated challenges to maintaining the therapeutic alliance. Incest victims have survived early abuse using some level of dissociation or splitting, some of whom may manifest forms of multiple personality disorder or borderline personality disorder. Incest survivors are also prone to suicidal and homicidal feelings, as well as to self-abusive behaviors. The subjects identified various demanding boundary issues in treating this population, including maintaining therapist limits in the therapy relationship, contact with clients after hours, and use of "safe touch." The subjects found that these clients usually place them psychologically in the role of the "abuser or perpetrator" as well as
"all-giving parent" which can be very demanding and draining. The subjects found many advantages in being a female which treating female incest survivors, due in part to a greater awareness of women's vulnerability to abuse in society and the resulting identification between female clients and therapist. Although they did not identify this as demanding, it would seem that therapist identification with the victimization of her female clients may also be an additional demand. One subject said that it is challenging to be the same gender as the "passive parent who did not protect" as well as a female perpetrators. Although they said that they are well seasoned by their years of experience, they said that this does not make the work easier emotionally. They said that it is emotionally demanding to be authentic and present with clients as they deal with the after-effects of incest.

Question 3

What do female outpatient therapists report as being the most demanding features of therapy when they first began treating adult female incest survivors?

When they first began treating this population, the subjects said that they were unprepared to deal with the demands of treating this population. One subject said "I didn't know what the hell I was doing!" and was responding to the "incredible pain and drama [of this population] with a limited number of tools." Another subject described herself as "green back then," and said that treating this population was "overwhelming" due to grappling with her own
disbelief, her ability to absorb the stories and not carry them, and
the challenge to her beliefs about goodness. One subject said that
she was "naive and not tuned in" to the issues of this population.
She said that her experience with this population has unfolded grad-
ually under good supervision, so that her early experiences were not
draining.

Question 4

What are the differences, if any, in what female outpatient
therapists report as being the most demanding features of therapy
when they first began treating adult female incest survivors compared
with their current experience after at least 8 years treating this
population?

One difference is that the subjects report that when they first
began treating this population they were not prepared to deal with
demands and complexities of dealing with this population. After 10
years experience, the subjects did not mention this as a current
issue. To the contrary, they identified the many ways they have pre-
pared themselves to treat this population, including supervision,
personal therapy, peer consultation, attending workshops, reading
books, and seeking specialized training. They also presented them-
selves as therapists well-versed in the complexities and demands of
treating incest survivors.

After their 10 years experience, they testify to the continuing
demands of treating this population. They said that it is very
emotionally demanding to be authentic and present with clients
telling their stories of abuse and revealing their pain and vulnerability. One subject suggested that knowledge brings additional demands like "bracing" herself when a client begins to tell a story of abuse and understanding how much the client will suffer in the course of therapy.

It would appear that their 10 years of experience has allowed them to develop the knowledge and skills to treat clients having histories of more severe abuse. Two of the subjects specifically mentioned treating clients with histories of ritual abuse. All of the subjects dealt with forms of multiplicity or severe dissociation in their incest clients, and one subject reported having 50% of her practice comprised of clients diagnosed with multiple personality disorder. Being more experienced therapists may mean that they have reputations which attract referrals of clients who are more severely impaired by childhood incest trauma, like those clients diagnosed with MPD.

They all indicated that they work with many of their incest survivor clients long term, for 2 or more years (in one case 10 years). Such long-term experience would be an added difference of their current experience compared to their first years treating this population. This factor may add to the intensity and impact on the therapist of the client's traumatic material and relational features of treating this population. It may also offer the therapist greater opportunity to assist the client in achieving constructive change in her life with accompanying satisfaction for the therapist.
Question 5

When female outpatient therapists reflect on the impact of treating adult female incest survivors for 8 years or longer, will they report any changes in their cognitive schemas, or their basic beliefs about themselves or others?

One or more subjects reported lasting changes in both positive and negative directions in their cognitive schemas having to do with safety, trust/dependency, esteem, independence, power, intimacy, and frame of reference for themselves, their clients, and their children. Table 1 summarizes the lasting change for each subject in each of the cognitive schemas regarding beliefs about herself and her clients.

Table 1 summarizes the lasting change for each subject in each of the cognitive schemas regarding beliefs about herself and her clients.

Question 6

Do the self-reported responses of experienced female outpatient therapists to treating adult female incest survivors appear to support McCann and Pearlman's (1990b) model of vicarious traumatization, when treating this population of trauma victims?

Yes, the self-reported responses of the subjects in this study demonstrated negative lasting changes in their beliefs in one or more of their cognitive schemas as a result of treating this client population. These negative lasting changes correspond to the examples cited by McCann and Pearlman (1990b) as evidence of a process of vicarious traumatization in the seven cognitive schemas (See Appendix E, Unique Coding System). Two subjects demonstrated negative lasting change in each of the following cognitive schemas: their trust of
others, the safety of their children, and their frame of reference. One subject demonstrated negative lasting change in each of the following cognitive schemas about self: safety, intimacy and connectedness, and esteem—that others are benevolent and worthy of respect. The self-reported responses of the experienced female outpatient therapists in this study who have treated this population for over 10 years appear to support McCann and Pearlman's model of vicarious traumatization.

**Question 7**

When examining the responses of female outpatient therapists to treating adult female incest survivors, are there variables which have not been addressed in the literature, which would suggest further study?

Yes, the lasting change in a positive direction demonstrated by the experienced female outpatient therapists in six out of their seven cognitive schemas as a result of treating adult female incest survivors appears to be a variable that has not been addressed in the literature. Literature addressing the effects on therapists occasionally mentions some of the rewards of treating these clients. The positive lasting change in the cognitive schemas of experienced female therapists demonstrated in this study has not been noted by McCann and Pearlman (1990a, 1990b) or other researchers studying effects on therapists. It appears that lasting change in female therapists' cognitive schemas can occur in either a negative or positive direction. In fact, both positive and negative lasting
changes may be demonstrated in one cognitive schema simultaneously, as reported by one subject in this study.

Hypotheses

This study was designed to provide a qualitative analysis of the data which would confirm or disconfirm the following hypotheses.

Hypothesis 1

Female therapists with 8 years or more experience treating female adult incest victims will report lasting changes in at least one of their cognitive schema, for example, their sense of safety, esteem, independence, trust/dependency, power, intimacy/connectedness, and their frame of reference.

This hypothesis was confirmed by the study. All of the three female subjects in this study demonstrated lasting change in both a positive and negative direction in more that one of their cognitive schemas. Lasting change was demonstrated by at least one or more subjects in beliefs about self in each of the cognitive schemas mentioned. Table 1 summarizes these results.

Hypothesis 2

Female outpatient therapists will report lasting changes in their sense of safety relating to their significant others.

This hypothesis was confirmed by the study. All of the subjects demonstrated lasting change in their beliefs about the safety of their significant others, specifically children. Two subjects
reported negative lasting changes in their beliefs about the safety of their children. The third subject demonstrated both positive and negative lasting changes in safety (as well as trust and esteem) for her significant others, including the children of her friends.

**Hypothesis 3**

Female outpatient therapists will report lasting changes in their sense of intimacy, or being relationally connected to others. This hypothesis was confirmed by the study. All of the subjects demonstrated lasting change in their cognitive schema of intimacy and connectedness as a result of treating this population. Two subjects demonstrated positive lasting change in their beliefs about intimacy and connectedness for both themselves and their clients. The other subject demonstrated negative lasting change in her beliefs for both herself and her clients.
CHAPTER V

DISCUSSION OF FINDINGS: IMPLICATIONS AND EXTENSIONS

The findings of this study have demonstrated that one or more experienced female outpatient therapists reported lasting changes in both positive and/or negative directions in their cognitive schemas having to do with safety, trust, esteem, independence, power, intimacy/connectedness, and their frame of reference as a result of treating adult female survivors of incest. This study's findings have also demonstrated support for McCann and Pearlman's (1990a, 1990b) model of vicarious traumatization, in that all three of the subjects reported negative lasting changes in one or more of their cognitive schemas regarding beliefs about themselves in the areas of safety, trust, esteem, intimacy/connectedness, and frame of reference as a result of treating this client population. This study found the highest number of lasting changes in the cognitive schemas of safety as well intimacy/connectedness. An unexpected finding was that experienced female therapists reported positive lasting change in six out of seven cognitive schemas as a result of treating this population. This study also found that experienced female therapists report that there are unique relational features about treating adult female survivors of incest which make this therapeutic work continually demanding.
In this chapter, the results of the study will be considered in relation to the concepts of (a) burnout, (b) secondary PTSD, (c) traumatic countertransferences, and (d) countertransference responses, which have been discussed in Chapter II. In addition to the findings summarized in Chapter IV, this chapter will occasionally draw on additional data from the subjects' interviews as well as the pilot interviews that appear relevant. This chapter will also present an attempt to extend McCann and Pearlman's formulation of the transformational process of cognitive schemas to account for the positive lasting changes in subjects' cognitive schemas, a finding not anticipated from the current literature. There will also be an attempt, using the findings in Chapter IV and the literature, to develop an expanded concept of vicarious traumatization which focuses on the interaction between traumatic content of therapy material and the relational processes involved in incest survivor treatment. Recommendations for both supervisors and therapists for the training and preparation of female therapists treating this population will be discussed. The limitations of this study will be reviewed. Finally, recommendations for future studies will be suggested.

As the several conceptualizations about the effects of treating incest survivors are considered, it is important to note that as the researcher examined subjects' data, it often was possible to discern some level of evidence related to one or more conceptualizations from a single sample of subject response. This is an expectable feature of such an analysis because subject statements have multiple meanings depending on the frame of conceptualization from which they are
Current Conceptualizations Regarding Therapist Responses to Treating Trauma Victims

Burnout

The results of this study do not appear to indicate that the experienced female therapists in this study demonstrated significant signs of burnout as a result of treating adult female survivors of incest over the last 10 years. Their accounts of their experiences did not give indications that they saw themselves as depressed, bored, or discouraged by these clients, or experiencing a loss of compassion. Some of the responses demonstrating negative lasting change in cognitive schemas may reflect some evidence of cynicism. For example, two subjects appeared to demonstrate a more cynical view of trust when one reported that she "no longer takes much at face value and families are largely screwed up" and the other "has less trust that people are telling the truth." However, such interpretive evidence would require further research data to clearly establish its validity. Overall, the therapists appeared to appreciate working with this population and demonstrated a variety of positive lasting changes in their cognitive schemas which they credited as resulting from treating this population; this was especially true for two of the three subjects.

Secondary Post-Traumatic Stress Disorder

Although this study was not designed to specifically test the
adequacy of this conceptualization, most of the symptoms of secondary PTSD noted by Colrain and Steele (1992) did not seem to be demonstrated clearly in the self-reported experiences of the subjects in this study. Some secondary PTSD symptoms may have been suggested to some extent by the subjects in this study: All of the subjects reported challenges in maintaining limits and boundaries with these clients. One of the subjects reported many alterations in the usual therapy boundaries, including use of "non-sexual touch" and celebrating a client's birthday in session. Further exploration would be needed to determine whether these examples represent "increasing difficulties in maintaining boundaries" (Colrain & Steele, 1992). Two subjects reported a greater awareness of evil and abuse in the world, but not necessarily a "preoccupation" with this. One subject reported feeling more unsafe and two other subjects reported feeling a decrease in their trust of others. One subject reported feelings of isolation from family and colleagues who may not understand the demands of her work. Two of the subjects reported that they were "overwhelmed," early in their careers. One implied that she felt incompetent, saying "I didn't know what the hell I was doing back then," and another said, "I was green back then." One subject reported that she was a "workaholic," but it is not clear whether this represents an "addiction" (Colrain & Steele, 1992) for her.

The results of the study suggest partial support for symptoms of secondary PTSD identified by Colrain and Steele (1992). A more focused exploration of the symptoms of secondary PTSD with experienced female therapists is needed to establish the extent to which
such therapists demonstrate these symptoms and to establish the validity of this conceptualization.

**Traumatic Countertransference**

The results of the study suggest that experienced female therapists reported some of the traumatic countertransferences conceptualized by Herman (1992). She identified feeling "suddenly incompetent and hopeless" (p. 141) as one kind of traumatic countertransference. As discussed earlier in the prior section, two of the subjects reported feeling "overwhelmed" early in their careers. They suggested that they felt incompetent at first, although they did not mention feeling hopeless. It is not clear whether these were responses to specific client traumatic transferences and/or more generalized responses to the overall demands of treating adult female incest survivors.

Herman (1992) noted that another traumatic countertransference was "assuming a stance of grandiose specialness or omnipotence as a defense against helplessness" (p. 143). In her style of talking about her competence and role with clients, Subject 1 gave suggestions of such a stance. In response to suicidal talk and gestures by clients early in her career, she said that she assumed a role of trying to control whether clients would live. She said that she now recognizes that this choice is up the clients. She sounded a little grandiose when she stated, "I have the power to change anything I set out to change," and said that her knowledge was far beyond other colleagues in her area. She stated "I don't want to sound pompous, but
my knowledge and skill is so far beyond where they [local therapists] are that it's not very helpful to even spend time there. They are just beginners at what they're doing." Although she seemed confidently competent, balanced with a lively sense of humor, further exploration would be needed to determine whether her strongly confident stance serves as a defense against feelings of helplessness.

Herman (1992) suggested that assuming the role of rescuer as a defense against helplessness is another type of traumatic countertransference. Such a role may involve violation of the boundaries of therapy. Subject 1 revealed that early in her career she would lie awake at night thinking, "What am I going to do? How do I fix this?" When her clients would call in crisis, she said, "like any beginning therapist, you tend to extend more than you should because you think [said with emphasis], "This time we'll turn the corner, this time." She suggested that this self-expectation that she could "fix" the client contributed to her extending herself in lengthy emergency interventions. These early career responses of Subject 1 suggest a rescuing role in response to feelings of helplessness, with blurring of constructive therapy boundaries.

Herman (1992) also noted that identification with the victim's rage and subsequent mismanagement of therapist rage is another type of traumatic countertransference. The results of the study suggest that experienced female therapists experience anger and rage at clients' perpetrators, as well as in more generalized ways. All of the subjects conveyed some of the intensity of their anger at their client's perpetrators. Commenting that she was angry that her
clients' perpetrators will never experience societal consequences, Subject 1 said, "I just hope there is a hell and they burn there forever." As a way to "defuse my countertransference," she said she has recently imagined driving over to the home of the father of a client. She stated "You know, if I drove over to his house [raises her voice with intensity and anger] "what would I say right now, what would I say, Oh boy!" She then laughed and seemed to relax. Subject 2 conveyed her anger at clients' perpetrators who were former therapists. She said,

This makes me very angry that there are still male therapists in this town who have abused clients and they're still working. And I want to get a sense of real Oomph behind my clients, not that I want them to go out and sue their abusers.... I just mean to have a powerful sense of protest that they can make.

She strikes her hand on the desk as she says this]. Subject 3 said that she often feels rage and the "urge to punch someone." These examples suggest that these subjects may identify with their clients' rage, feeling dramatic rage about their clients' experiences; further exploration would be needed to determine whether they process and manage their anger in appropriate ways.

Another type of traumatic countertransference was "experiencing profound grief and succumbing to despair" (Herman, 1992, p. 144). While Subject 3 reported commonly feeling sadness in response to client abuse, none of the subjects reported responses of grief and despair. During her interview Subject 2 displayed what may have been grief in an empathic identification with her clients. In response to a question about any powerful experiences she has had, she reported
the following common experience with many clients. Although they present as very competent women, she said they often appear to "crumble" as they cry and talk about their abuse, revealing their fear and shame. As Subject 2 related this, her own face crumbled and she cried openly, saying "it's so very, very powerful an experience." After she cried for a few minutes, she said that she does not talk about this much, and with some firmness said that she does not cry with her clients. She said that such experiences make her "very respectful" of both sides of her clients. Since the researcher did not clarify with the subject what her tears represented, one can only speculate about its meaning. After her tears, Subject 2 seemed to return to her former state, composed and actively interested in the interview process. She did not seem to display lingering effects of her affective expression, with signs of grief or despair.

Herman (1992) said that traumatic countertransferences may take the form of identifying with the feelings of the perpetrator, including being skeptical of the client's story. Subject 2 reported not being able to relate to the story of one of her clients and wondered about the client's veracity. Subject 3 said that early in her career she struggled with believing some of the client stories. Further exploration would be needed to determine whether these responses of being skeptical of client's stories are examples of an identification with the perpetrator or struggle with traumatic material.

The results of this study suggest a partial support for Herman's (1992) conceptualization of traumatic countertransferences. The results of the study did not demonstrate three other types of

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traumatic countertransference noted by Herman, namely experiencing
helplessness with an underestimation of knowledge and skill, experi-
encing witness guilt, and existential panic with uncharacteristic
dissociative experiences. A more focused exploration with experi-
enced female therapists for the range of traumatic countertransfer-
ences is needed to establish the validity of this conceptualization.

Countertransference

The results of this study offer some support for many of the
countertransference conceptualizations reviewed earlier in Chapter 2.
The most prominent of these formulations will be considered in the
light of the study's findings.

Countertransference Responses to Traumatic Content

Some authors (Briere, 1989; Gelinas, 1983; Herman, 1992) have
suggested that exposure to traumatic content prompts a variety of
countertransferences. The study's findings include a range of affec-
tive countertransference responses of female therapists to the trau-
matic content shared by their clients. Therapists reported feeling
sadness about client's experiences, feeling frightened by a satanic
alter personality of a MPD client, and feeling dread and bracing
oneself before some painful material is to be shared. The most
commonly and intensely reported responses were anger and rage, fre-
quently directed at clients' perpetrators (see discussion in prior
section). It is suggested that the anger of Subjects 1 and 2 toward
their clients' perpetrators may have become channeled into a more
generalized anger response, taking the form of their strong call for protest and justice for their clients (see discussion in prior section).

A commonly reported response to traumatic content noted in the literature were feelings of isolation (Briere, 1989). Subject 1 talked about the isolating impact of not being able to talk about traumatic material in order to maintain confidentiality. She also was not able to find much support in her practice with colleagues who were unfamiliar with the kind of clients she treated. She demonstrated negative lasting change in her cognitive schema of intimacy/connectedness. Two other subjects did not report such isolation, and instead reported greater intimacy and connectedness with other therapists and friends as a result of treating this population. Both reported utilizing active therapeutic support systems including supervision, personal therapy, and peer support in their own practices (see discussion in Chapter IV).

Another common response to traumatic content noted in the literature is the challenge to therapists' basic beliefs, which is supported by the evidence of vicarious traumatization found in this study. It is suggested that the cumulative experience over time of a therapist's countertransference experiences of having basic beliefs repeatedly challenged by many incest clients' stories may result in lasting negative changes in a therapist's cognitive schemas. For example, in the area of beliefs about safety, one subject demonstrated negative lasting changes in her beliefs about her own safety and two subjects demonstrated negative lasting changes in their
beliefs about the safety of their significant others. In the area of trust, two subjects demonstrated negative lasting changes in their beliefs. In the area of intimacy/connectedness, one subject demonstrated negative lasting changes in her beliefs about self. Finally, in response to traumatic content, "where unbelievable things have been shared" two subjects demonstrated negative lasting changes in their frames of reference.

Countertransference Responses to the Relational Features of Treating Incest Survivors

The results of the study suggested that challenges to female therapists' boundaries are one of the demanding features of treating incest survivors. It is suggested that such challenges to therapist boundaries result from the powerful relational pull of the projective identifications within the transferences of incest survivors, in effect, pulling the therapist to be something that she is not. It is also suggested that the ways that the subjects have dealt with these boundary challenges represent the ways these therapists have dealt with their own introjective identifications within their countertransferences.

Some authors cited earlier have addressed some of the transference-countertransference dynamics with incest trauma survivors which may have a powerful impact on therapists. Transferences include the client's conscious and unconscious feelings and thoughts toward the therapist. Projective identification is a powerful unconscious interactional process within the client's transference. According to
Tansey and Burke (1989), using projective identification for both defensive and communicative functions, a client unconsciously induces the therapist to experience a state which matches or complements the client's thoughts, feelings, or images. These authors have proposed that the therapist takes in or identifies with the client's projected material by way of introjective identification, which is an unconscious process within the therapist's countertransference. Thus, a therapist may actually experience trauma-generated client representations about self or others, which may be dissociated, projected and be induced in the therapist by way of the client's unconscious projective identifications. Peebles-Kleiger (1989), Catherall (1991) and Lisman-Pieczanski (1990) have addressed the powerful countertransference issues for therapists in response to the trauma victims' projective identifications. Aron (1992b) has suggested that the therapist is always co-participant with clients in a constant process of "reciprocally constructed transference-countertransference integrations" (p. 504) and relational patterns. These formulations about the dynamics between client and therapist suggest the relational experience with incest trauma survivors may result in actual penetration of trauma-generated representations into the therapist's inner experience. Such ability of clients to penetrate or influence the therapist's inner world, may help explain the potentially traumatic influence of treating trauma survivors, including incest trauma, on the therapist and her boundaries.

Since this study did not specifically explore therapists' experience with clients' projective identifications, the following
examples include inferences suggested by the data. These hypothetical examples illustrate the elements of the powerful relational pull on the therapist of the transference-countertransference dynamics with incest survivors and their influence on female therapists' boundaries. The subjects all mentioned the pull of incest survivors' suicidal tendencies and other crises. The self-beliefs of a suicidal incest survivor client might be "I am helpless, hopeless, weak and do not deserve to live." Inducing her therapist to feel and embody some of the client's split-off qualities she cannot own or tolerate within herself, the client's unconscious projective identifications toward the therapist might be "you are strong, all-giving. Only you can give me hope. You have to save me!" Responding to the client's pull, the therapist's unconscious introjective identifications might be, "I am strong, have hope, have the skills to save the client from suicide and am the only one who can rescue this client." The therapist's conscious countertransference responses to such own unconscious introjective identifications could take many of the forms suggested by the data. Countertransference responses might include anger and frustration at a client's pressure and intrusion on private time (Subject 1). Another countertransference response might be feeling drained (Subject 3) while another might be feelings of omnipotence and exaggerated importance (suggested by Subject 1).

In order to manage such countertransferences and the demands of clients' projective identifications, therapists may respond by either strengthening or loosening their personal and therapy boundaries (see Figure 1).
Figure 1. Client Relational Pull on Therapist Boundaries.

All of the subjects frequently addressed how attending to therapy boundaries is crucial in treating this population. Subjects 2 and 3 suggested ways they try to strengthen their boundaries as they stressed the importance of being clear about contact outside of the therapy hour and the limits in the therapy relationship. Subject 3 stated that she has some "strict guidelines" around the use of touch with clients, but finds that her guidelines continue to be challenged. Subject 1 said that she has some boundaries that she does not violate, but loosens some of the traditional boundaries, such as being more available outside the therapy hour, use of "non-sexual touch," and some "acts of kindness." It is worth noting that some authors (Mayer, 1988; Putnam, 1989) endorse altering some therapy boundaries in the treatment of MPD clients, such as having longer sessions and greater availability outside of sessions.

As well as the demands these place on the therapist, some authors (Catherall, 1991; Peebles-Kleiger, 1989) have addressed how the pull of incest survivor projective identifications may be used by
the therapist for empathetic knowledge of these clients' inner world. While the subjects did not discuss clients' unconscious projective identifications, the results of this study suggest that the subjects were aware of some aspects of client transferences, the ways this population positions them psychologically in various roles, and in some cases how they use their countertransferences for knowledge of client dynamics. For example, in response to being placed in the role of abuser, the subjects reported the following countertransference responses and how they used them. Subject 1 talked about how she was furious at being placed in a position one Saturday to break confidentiality due to a client's suicidal threat. She described how she contained and processed her feelings for a few hours, gaining awareness that the client was placing her in the role of abuser. She used this knowledge to confront the client with her reenactment of abuse. This appears to be an example of a therapist reflecting on her countertransference to gain an understanding of the demands of the client's projective identifications. Subjects 2 and 3 also reported being placed in the abuser role. Subject 2 did not relate much of her countertransference response except to talk about how she used the experience productively with the client. Subject 3 said that she feels uncomfortable when seen as an abuser. When she is the same gender as her client's abuser she also suggested that she finds some of the transference-countertransference features "sticky."

The subjects also revealed some of their countertransference responses to some other relationally demanding features of treating this population. Subject 2 said she can be surprised and discouraged
to find how little a client with whom she has worked a long time may trust her when they get into some in-depth work. Two of the subjects reported being frightened by experiences with satanic personalities or alters of their clients. It is suggested that being frightened may be a countertransference response to relational features of such dissociative clients as well as to the content that may have been shared.

Some of the subjects' countertransference responses appeared similar to countertransference hate. MacCarthy (1988) suggested that countertransference hatred may be seen in such therapist responses as disbelief, blame, indifference, outright hostility, as well as feelings of confusion and desolation. As discussed earlier, Subject 2 reported not being able to relate to the story of one of her clients and wondered about her veracity. Subject 3 said that early in her career she struggled with believing some of the client stories. Subject 1 reported intense countertransference anger at her client's reenactment and placing her in the role of abuser, possibly forcing her to break confidentiality. Early in her career, she also reported feeling confused about what she should be doing with her clients. It appears that the subjects experienced some forms of countertransference hatred in their relational experience with this population, although it does not appear that any have reached the place of "turning their backs" (MacCarthy, 1988, p. 119) on these clients.

**Overidentification With Incest Survivors**

Briere (1989) found two prominent sources of negative
countertransference were the therapist's childhood experience of abuse and gender socialization. While the therapist's childhood abuse experience fell outside the parameters of this study, the study's findings offer some support for his formulation of the impact of female gender socialization on countertransference. Briere and others (Bigras, 1990; Courtois, 1988; Herman, 1981) have found that overidentification with incest survivors is probably the most frequent response of female therapists. Briere suggested that female therapists may respond with two overidentification patterns: of overinvolvement and a defensive counterpart of underinvolvement. Do the findings suggest such overidentification?

Some of the subjects' responses suggest such overidentification with female incest survivors. In their discussion of advantages offered female therapists due to the identification possibilities between female clients and therapists, the subjects revealed some of the basis for their own identification with the victimization of their clients. They reported that being a female gave them greater awareness of ways women may be abused in society, including the meaning of sexual violation. Briere (1989) said that overinvolvement may take the form of agitated concern or extreme nurturance. Early in her career, Subject 1 may have demonstrated such overinvolvement when she suggested that she had tendency to over-respond to client "emergencies." She said:

Early on, like any beginning therapist, you tend to extend more than you should because you think [said with emphasis], "This time we'll turn the corner, this time-so I'll do this, this time." And you begin to understand how this is a long term project and that's unrealistic.
This "extending more than you should" may be a way of complying with the pull of her client's projective identifications to do more and be more available. If the formation of women's gender identity have included socialization to be flexible, compliant caregivers, a female therapist may be more vulnerable to such demands embedded in a client's projective identifications. This may influence how she responds to clients' projective identifications and heighten her overidentification with incest survivors.

Some other types of therapist responses noted in this study suggest an overidentification with incest survivor clients. The experience of Subject 2 crying during the interview as she recalls her clients revealing their fear and shame in response to their abuse experiences may suggest her overidentification. The common anger and rage responses of the therapists discussed earlier, most frequently directed at clients' perpetrators, may reflect an overidentification with their clients. Female therapists struggle with the horrible content which is shared, with resulting containment and isolation issues, with the pull of client projective identifications in the relational process, and identification with the victimization of their female clients may result in an overidentification with this population. Although not addressed in this study, the possibilities for overidentification with incest clients may be greater if the therapist herself was a sexual abuse or incest survivor.

Positive Lasting Change in Cognitive Schemas

This study discovered the unexpected finding that experienced
female outpatient therapists demonstrated as many positive lasting changes in their cognitive schemas about self as negative lasting changes. Although McCann and Pearman (1990b) and others (Briere, 1989; Courtois, 1988; Herman, 1992) have mentioned some of the rewards and positive outcomes therapists experience as a result of treating trauma survivors, it appears that experienced female therapists may demonstrate both positive and negative lasting changes in their cognitive schemas as a result of treating incest survivors. In some cases these positive lasting changes appear to be the mirror opposites of the negative lasting changes described by McCann and Pearman (1990b) resulting from the transformational process they term vicarious traumatization. For example, as a result of treating this population Subject 3 reported feeling more safe which seems to be the mirror opposite of the more "paranoid" and less safe position described by Subject 1.

Based on these findings, it appears that experienced female therapists may expect treating adult incest survivors will prompt lasting change in some of their cognitive schemas, and these changes may be in either negative or positive directions, or both. An expansion of McCann and Pearman's (1990b) formulation of vicarious traumatization, which currently captures only the negative direction of the transformational process, may be indicated. Such an expansion of their model would include the positive as well as negative lasting changes in the transformational process in female therapists' cognitive schemas as a result of treating this population.
Two Factors Contributing to Lasting Change in Cognitive Schemas

As discussed earlier, both traumatic content and the relational process features of treating incest survivors contribute to the range of countertransference responses cited in the literature and supported in the findings in this study. Do the findings of this study suggest that both traumatic content and the relational process features of treating this population contribute to the lasting cognitive changes of female therapists? Yes, it is suggested that both contribute to both the positive and negative lasting changes in cognitive schemas, noted in this study. In addition, it will be suggested that these two factors may have an interactive effect intensifying their impact on therapists.

Traumatic Content

Exposure to the traumatic content of incest survivors has been identified by some authors as a contributor to negative effects for the therapists, including the management of demanding countertransferences (see prior section). A few authors seem to suggest that it is the traumatic content of what is shared repeatedly over time which is most damaging to the therapist. Herman (1992) has said that "repeated exposure to stories of human rapacity and cruelty inevitably challenges the therapist's basic faith . . . heightens her sense of personal vulnerability" (p. 141), and it increases her fearfulness and "distrustfulness even in close relationships" (p. 141). McCann and Pearlman (1990b) have stated that exposure to the
traumatic content, namely graphic and painful material presented by trauma victims in interaction with the therapist's unique cognitive schemas, accounts for the negative lasting changes in cognitive schemas.

The results of this study also support the negative lasting changes in cognitive schemas due to exposure to traumatic content. When asked about the most demanding features of treating this population, one subject stated that dealing with traumatic material was difficult at the beginning of her career. Subject 3 stated that she found treating adult female incest survivors "overwhelming" because she grappled with her own disbelief, her "ability to absorb and not carry [the stories] with you and how horrendous that can be, as well as challenging your beliefs about goodness."

Two of the subjects in this study suggested that exposure to traumatic content contributed to some of the negative lasting change in their cognitive schemas regarding trust and safety. Subject 3 stated that "repeated exposure to people who have been damaged, . . . by people who are supposedly trustworthy in their life . . . I've been continually reminded of how much people can abuse trust." She credited this exposure to contributing to a lasting negative change in her sense of trust. Subject 1 suggested that exposure to stories of abuse has contributed to a lasting negative change in her sense of safety. She stated, "my experience in working with abused populations is that I have an entirely different concept of evil in the world. . . . I would say I am much more paranoid . . . much more aware of how I could be on the receiving end, and aware that my
client's families could retaliate at me at any point in time, though they have not."

It therefore appears that there is a relationship, as the literature suggests, between exposure to traumatic content and therapist countertransferences, possibly traumatic countertransferences and lasting negative changes in cognitive schemas.

**Relational Process Features**

The relational demands, or process features of treating incest trauma survivors reported by the experienced female therapists in this study not only trigger countertransference responses (discussed earlier), but also appear to contribute to lasting changes in therapists' cognitive schemas.

In her recent book, *Trauma and Recovery*, Judith Herman (1992) has said that for trauma survivors "recovery can only take place within the context of relationships; it cannot occur in isolation" (p. 133). She and others (Gelinas, 1983) have addressed the relational deficits of such survivors and how they reenact their trauma in current relationships, including the therapy relationship.

The subjects discussed the many relational demands in treating this population which have been summarized in Chapter IV. Do their narratives suggest that the relational process demands of treating this population have contributed to the lasting changes in their cognitive schemas? The subjects' self-reports about the influence of treating this population on their countertransference experience, on their dreams, on their affective responses, and on their physical
responses suggest that incest clients' can have a powerful impact on female therapists' inner experiences. It has also been suggested that clients' projective identifications may put demands on the therapist to be something that she is not, e.g. "the all-giving one," the abuser, or demand the therapist to provide more containment, e.g., longer sessions, more frequent contact outside of sessions. It has been suggested that female therapists' countertransferences to such client demands may be to strengthen or loosen the therapy boundaries.

It is suggested that the process of assimilating and accommodating to these relational demands is also a powerful factor contributing to the lasting changes in therapists' cognitive schemas. While the subjects were not asked about whether the relational features of treating this population contributed to the lasting changes in their cognitive schemas, some of their narratives suggest these demands contributed to some changes. Subject 1 said that her work is emotionally demanding "because you . . . have to go into the client's world and be there and then lead them back out . . . it's very demanding to enter experiences of betrayal." She demonstrated negative lasting change in her beliefs about trust for herself. She also mentioned that she has had many powerful experiences treating incest survivors diagnosed with MPD, some with satanic alters. She demonstrated negative lasting change in her cognitive schema about safety for herself, saying "I have an entirely different concept of evil in the world . . . I am much more paranoid." She said that her work with this population is
such powerful and creative work that it could obliterate other connections or time for other connections. . . . it has the potential to seduce someone into a kind of pseudo-intimacy, where your clients are the closest to you, which is not . . . the way you want things to be. But that pull is there, because you share at levels that are very, very deep.

She demonstrated negative lasting change in her cognitive schemas of intimacy/connectedness.

In the area of intimacy/connectedness, Subject 2 demonstrated positive lasting change in her cognitive schemas for both herself and clients. As a result of observing her clients in group work, she said that "their ability to be connected is rather amazing when you see how isolated they have been." This suggests a lasting cognitive schema change as result of the relational process features of treating this population.

Prompting her to work on her own issues, Subject 3 spoke of how treating this population has been growth-producing for her, contributing to positive lasting changes in her sense of intimacy and connectedness. In the area of safety, Subject 3 demonstrated positive lasting change in her beliefs about her clients' safety. She credited this change to seeing how her clients could learn more about safety through the therapeutic relationship. She said, "I think it's a real difficult task to try and help people understand that they have more power (and safety) now than they had . . . largely through the safety and consistency of the therapeutic relationship [they] can experience more about that."

It is suggested that the relational process features of treating this population also contribute to the lasting changes in female
therapists' cognitive schemas. These relational process features have not been emphasized in McCann and Pearlman's (1990b) conceptualization of vicarious traumatization.

**Interactive Effects of Traumatic Content and Relational Process**

To summarize, some authors highlight the impact of the traumatic content of incest trauma survivors on therapists. Other authors highlight the impact of relational process demands of treating incest survivors on therapists. Both features are supported by the findings of this study. To extend the conceptualizations of these two factors a step further, it is suggested that traumatic content and relational process may have interactive effects which intensify the impact on female therapists. It is suggested that traumatic content may intensify the impact of the relational process features of treating this population. And the relational process features of treating incest survivors may intensify the impact of the traumatic content the therapist hears and must contain. While such interactive effects have not been clearly addressed in the literature, some of the data in this study suggests such interactive effects. A few examples from the subjects' narratives, as well as one from one pilot interview will be given to illustrate this thesis.

**Relational Process Affects Assimilation of Traumatic Content**

Considering ways that the relational process may intensify the impact of the content, two examples will be considered. The first comes from the "powerful experiences" with incest survivors reported
by Subject 2. She reported that as many of her clients, who are
"real competent women," talk about their memories, their faces "just
kind of crumble. . . . And they start to cry." She said that they
can be "on top of things" in their careers, but they come "in here
and the contrast is incredible of how frightened she is, how aware
she is of my response to her . . . there is such a sense of shame
with these people." As she related this experience her own face
softened and seemed to crumble as she cried openly for a few minutes.
She said, "it's so very, very powerful an experience. . . . I don't
talk about it much. And I don't cry about it with them." As her
very "competent" female clients talk about their traumatic memories,
it appears the pull of their relational process may intensify the
experience of hearing the content. Such client's relational process,
with the pull of their projective identifications, may induce Subject
2 to experience affect close to theirs, intensifying the experience
of hearing and containing their traumatic content. Having contained
her affective experience with these clients for some time, she allows
herself to express it in the interview.

Another example is drawn from one of the pilot interviews. It
is the intention to bring in this graphic example to illustrate the
powerful interactive effects of traumatic content and process.
Although two of the three subjects referred to such frightening
experiences with their clients, they chose not to talk about them
specifically. Subject 2 stated that these are not experiences that
she likes to talk about. The subject from Pilot A reported the
following experience:
some client had regressed and she was a ritual victim that they had aborted a fetus at that point, and was reliving it. And it was just agonizing. [said with distress in her voice] I've heard cries and I've heard screams, but this was the wail of an animal, I mean it was just—it just sent me cold. [She searches for words.] I was just—not fear, not—but at that point it felt as if I was there with her. It was just, it was too intense [to do] the distancing. And at that point . . . she was crouched down. . . . But, you know, she was wailing. [Said with amazement.] If I could have recorded it, it was the most awful sound I have ever heard. And I would want to say it was almost like the sound of dying—and my blood ran cold—whatever, whatever you can call it. . . . She was down there in her own little place, and it shook me.

But she came out of it and talked it through and stuff like that. And all I could do was go home and sleep. Didn't want to deal with it. Forget the progress notes that night. Luckily it was my last client and I was just, absolutely drained—Just, so—don't know what it was? But it sounds really corny, but it was almost like we joined.

[Said later about this and another experience.] But it was just, I guess, so regressed at such a young age, so—I guess the intensity of the pain [so much. It] was real hard at that point to keep boundaries, . . boundaries were blurred probably with that.

The relational process in this example involves an extreme form of dissociation on the continuum of dissociative conditions, namely the formation of multiple personalities. Incest has been the most commonly reported childhood trauma (68%) in MPD clients (Putnam, 1989). The presence of animal alters has been noted by Mayer (1988) and Putnam (1989).

Rather than being reported from an adult's style of relating about a past experience, as in the last example, here the traumatic content has been communicated through enactment of a very young child alter, or animal personality. The compelling nature of the enactment seems to intensify the chilling nature of the traumatic content,
drawing the therapist into the experience. Pilot A stated, "it was like we joined . . . the boundaries were blurred." She also stated that the client later came "out of it" and "talked it through," apparently talking about the traumatic memories with Pilot A. It is suggested that client relational styles involving blurring of boundaries may not only intensify the relational pull or demands on the therapist, but this pull may also intensify the impact of the traumatic content. The subjects in this study reported the common boundary problems of incest survivors, the common use of many forms of dissociation, including multiple personality disorder.

**Traumatic Content Affects the Relational Process**

From the example given above, it is also possible to see that traumatic content also affects the relational process. It is suggested Pilot A's relational experience with this client is intensified by the knowledge of the traumatic material. Would the client's howling have had the same impact on the therapist if she did not know the traumatic experiences which prompted the howling? Would Subject A have interpreted the howling as "the sound of dying" if she did not know that it was a response to the aborted fetus? That her "blood ran cold" and she was "shaken" and later "drained" seems intensified by her knowledge of the traumatic content. These disclosures suggest that the graphic and traumatic memories may intensify the impact of the process variables like client projective identifications. Traumatic content may thus intensify the relational impact on the therapist, contributing to intense countertransference
responses, like feeling "shaken" with her blood running cold, and challenge the therapist's boundaries. As Pilot A stated, "it was like we joined."

In concluding this brief consideration of the interactive effects of traumatic content and the relational process of treating incest survivors over time, it is suggested that the interactive effects of these two dimensions of treating this population are more obvious in such dramatic examples as the one given above. However, it is suggested that such interactive effects may be present in more subtle forms in less intense experiences. Further study is necessary to explore the validity of this conceptualization of the interactive effects of traumatic content and the relational process of treating incest survivors.

Therapists' Transformational Process Over Time

As discussed earlier, all subjects demonstrated positive and negative lasting changes in their cognitive schemas in response to treating incest survivors over the last 10 years. Lasting changes in cognitive schemas represent major psychological changes in a therapist's belief system. While the subjects attributed such lasting changes in their cognitive schemas to the impact of treating incest survivors for over a decade, it is possible that there may be other factors contributing to the lasting cognitive changes demonstrated by subjects in this study, like experiences with other challenging populations or other life experiences. However, it is also worth noting that the subjects appeared to give careful thought to the
source of a change in beliefs. In some instances, a subject reported a negative lasting change in a cognitive schema, but attributed it to another cause, like growing older (e.g., Subject 2 regarding safety). As indicated in the coding system (Appendix E) such responses were not coded as demonstrating lasting change since the subject did not specifically attribute the change to her work with this population. Only responses specifically attributed to treating incest survivors were considered as demonstrating lasting change in cognitive schemas within the parameters of this study.

As noted earlier, in response to the traumatic content, the relational process demands of treating this population and the interactive effects of content and process, experienced female therapists in this study responded with a variety of countertransferences, traumatic countertransferences and symptoms of PTSD. A few responses reported in this study are suggestive of some signs of burnout. It is suggested these conceptualizations and supportive data found in this study represent unique responses of each subject as she assimilates and accommodates to the traumatic content and relational process demands of treating this population. This process of assimilating and accommodating to these demands may take the form of a transformational process over time, in which the responses described in each of these conceptualizations may be found.

Within a therapy session the first, most recognizable responses may be the therapist's countertransferences. These represent the therapist's conscious and unconscious feelings and thoughts prompted by the interactive process with the client. As traumatic memories

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are shared and interact with the demands of the relational processes, the therapist may experience stronger countertransferences and/or traumatic countertransferences. As these responses accumulate over time with a variety of incest clients, they may coalesce into a syndrome of symptoms which take the form of secondary PTSD. As a therapist lives with the syndrome over time, attempting to assimilate her experiences, she may accommodate by changing her basic beliefs in the seven cognitive schemas identified by McCann and Pearlman (1990b). Such changes may occur in either a positive or negative direction. The sequence just described in a therapist's transformational process is depicted in Figure 2.

![Figure 2. Therapist's Transformational Process.](image)

Such a sequence is proposed based on the conceptualizations suggested by the literature and the partial support in the findings of this study. The retrospective nature of much of the subjects' reflections makes defining the sequencing of therapists' experiences over the last 10 years imprecise and approximate. While the sequence
outlined here is suggestive of steps in a transformational process, a particular therapist may find her process takes a different course. Further exploration, including longitudinal studies, would be necessary to test the utility of this formulation.

Therapists' cognitive schemas may be seen as a way of defining their beliefs and assumptions about self, other and the world. It would appear that these schemas could be seen as a type of boundaries for framing the ways they view reality. Challenges to therapist boundaries have been a common theme reported and discussed in this study. It is suggested that the lasting changes in cognitive schemas demonstrated in this study, resulting from a transformational process over time, represent another example or type of boundary challenge in treating this population.

Importance of Therapist Support System

Having suggested a sequence of steps in a transformational process which may result in lasting positive or negative changes in female therapists' cognitive schemas, the following additional observations are offered. Female therapists may expect that their basic beliefs, or cognitive schemas may be challenged in negative and positive ways. As part of the therapy process a therapist provides a safe container for both the client's traumatic memories and relational style formed through trauma. The therapist provides a kind of psychological holding environment (Winnicott, 1965) for the client to do her healing work of reestablishing a sense of safety, remembering and mourning, and reconnecting with their life (Herman, 1992). The
effects on a particular female therapist will also be influenced by her unique schema vulnerabilities, her own abuse history, and her level of self-awareness. Given the importance that subjects placed on boundaries issues and dealing with client anger and rage, female therapists who have vulnerabilities in these areas may be more prone to negative effects in treating this population.

The study's findings suggest that an active use of a support system offers a therapist opportunities to work through the range of powerful and very human negative effects, such as traumatic counter-transferences, symptoms of secondary PTSD and resulting challenges to their cognitive schemas. Just as the therapist provides a kind of psychological holding environment for the client, the therapist needs a supportive holding environment herself to process the traumatizing content and relational process features of treating this population. It appears that such a support system may provide ways to work through traumatizing material and even ways to formulate positive lasting changes in some cognitive schemas. Such a support system as a positive psychological holding for the therapist may ensure her continued psychological health and her continued effectiveness with this population, off-setting a possible vicarious traumatization process.

Implications for Female Therapists

As a result of treating adult female incest survivors, experienced female outpatient therapists may demonstrate lasting changes in both positive or negative directions in one or more of their
cognitive schemas having to do with beliefs about safety, trust/dependency, esteem, independence, power, intimacy/connectedness or frame of reference. They may experience negative lasting change, particularly in schemas having to do with one's beliefs about trust, safety of one's children, and their frame of reference. With self-awareness, training, adequate provision of a safe therapeutic environment for clients, and an active therapeutic support system, female therapists may moderate the traumatizing impact on them of the content and relational process features of treating this population, discussed earlier. To that end, the following suggestions are offered.

Suggestions For Female Therapists Treating Incest Trauma Survivors

Given special demands on female therapists who treat adult female incest survivors and the potential pressure for lasting negative change in their cognitive schemas discussed earlier, female therapists and their supervisors may benefit from several suggestions. Many of these suggestions may also be useful for male therapists treating this population.

1. This study has highlighted ways in which female therapists may over-identify with the traumatization of female incest clients. Female therapists may benefit from a therapeutic support system which includes males as well as females to offer balanced feedback and empathy from both genders. Such a balance might offset some of the over-identification process and possible generalization of anger towards men. Female therapists may seek male support among their
colleagues, supervisor, therapists, and/or friends. Two of the subjects talked about the value of peer support from female colleagues and another addressed the value of co-leading a group for survivors with a male colleague.

2. As suggested by the findings in this study, female therapists may experience the process of vicarious traumatization in their cognitive schemas having to do with trust/dependency on others, beliefs about the safety of their children, and their frame of reference. Supervisors of female therapists treating this population may help offset a vicarious traumatization process by reviewing the therapist beliefs in each of these schemas and assessing how these may be challenged by current client material. The following suggestions are offered to female therapists and their supervisors:

a. **Trust/dependency.** The supervisor may encourage the therapist to explore her beliefs about trust and dependency and how these may be challenged by treating female incest survivors. Such exploration may encourage the therapist to deepen her trusting process, although she may be more selective about whom she trusts. The supervisor may encourage the therapist to reach out for support and not withdraw in an isolating process. She may develop greater trust in those on whom she has chosen to depend—supervisor, peers, friends or partner.

b. **Safety of their children.** Female therapists with children, or possibly even grandchildren, may be especially susceptible to a vicarious traumatization process in their
beliefs about the safety of their children. Female therapists who treat female incest survivors may have special concerns about the safety of their children or of children in general, if they have no children of their own. Supervisors may encourage such therapists to be involved in leisure or social activities with families who are not absorbed with childhood abuse issues. Therapists may be encouraged to talk with colleagues with children to share challenged beliefs and engage in some reality assessment. Therapists may also benefit from talking with experienced therapists who have already raised children while treating this population, and may now have achieved a more positive transformation of their beliefs in this schema.

c. Frame of reference. The supervisor may encourage the therapist to identify the guiding beliefs in her frame of reference and engage in an assessment of how realistic some of these beliefs may be. For example, one of the pilot subjects stated that she began her career with very naive, "Pollyanna" kinds of beliefs which were severely challenged by her experiences treating this population. If this is the case, a supervisor may gradually help a therapist to explore more realistic guiding beliefs with which she can find meaning in the face of stories of betrayal and cruelty. Such assistance may help the therapist avoid or moderate a vicarious traumatization process. Such attention may even offer a therapist an opportunity to engage in
a process of positive transformation of her frame of reference.

3. This study suggests that female therapists may expect that their experience and learnings with this population will impact many of their beliefs, assumptions and expectations in such areas as safety, trust, intimacy/connectedness, and even their basic view of life. A therapist, possibly with her supervisor, may be advised to gain awareness of her own transformation process, including any accumulated negative effects contributing to cognitive changes. Awareness of her basic beliefs in these schemas can allow her opportunities to use them appropriately in her practice and in her life.

4. Female therapists may offset the process of vicarious traumatization by having a strong professional support system which includes the following components: regular supervision of their work with incest survivors as well as other cases is important; and regular peer consultation with colleagues, with whom a therapist can feel comfortable to share doubts and receive supportive confrontations, seems essential for the therapist's continued vitality. Such a support system may provide the psychological holding (Winnicott, 1965) a female therapist needs to work through the traumagenic effects on herself, including her affective responses, physical responses, dream/imagery responses, and any impact on her cognitive schemas. The two subjects who provided themselves a strong professional support system also demonstrated positive lasting changes in their schemas of intimacy/connectedness.

The importance of a professional support system is well
recognized by various writers (Briere, 1989; Herman, 1992; McCann & Pearlman, 1990a, 1990b) in the treatment of trauma survivors. Herman (1992) said that one of the guarantees for the safety of client and therapist is the therapist's support system. She stated, "The work of recovery requires a secure and reliable support system for the therapist" (p. 151), which should include a "safe, structured, and regular forum for reviewing her clinical work" (p. 151), and would preferably include both supervision and a peer support group. She suggested that therapists should expect to lose their balance at times with trauma survivors, and that "the guarantee of integrity" is "not omnipotence" (p. 151), but trust in others in her support system.

5. Seeking one's own therapy is important for the continuing psychological health of the therapist. This might include working through anger and rage, and working on any lingering traumatic effects, including persistent PTSD symptoms triggered by work with this population. It is essential for therapists who are survivors of childhood abuse, including incest, to work through the aftereffects in their own therapy. Personal therapy can provide the therapist with a base of self-knowledge of their own issues, including abuse history, their relational style, and vulnerabilities. Such self-knowledge is essential in treating all clients, including those with traumatized relational histories resulting in strong relational impairments. The therapist's task is to come to terms with her own issues so that she does not project early injuries onto her clients, respond defensively to and over-identify with client material.
Briere (1989) and others have emphasized the importance of personal therapy for therapists treating this population. One of the subjects (Subject 3) in this study credited her personal therapy with providing her an opportunity to work through, not only her own issues, but those triggered by clients, and form beliefs about herself which demonstrated positive lasting change in the areas of intimacy and safety.

6. Therapists need solid training by way of coursework, conferences or workshops in all aspects of treating this population. Supervisors of therapists treating this population should be knowledgeable of these issues, and encourage the education or training in their supervisees in the following treatment issues:

a. The trauma models which account for trauma induced aftereffects on survivors including PTSD and complex PTSD (Herman, 1992). Therapists need training in the models of treatment for survivors in childhood sexual abuse, including incest (see Briere, 1989; Courtois, 1988; Gil, 1988; Herman, 1992; McCann & Pearlman, 1990a, 1990b).

b. The principles of providing a safe therapy environment for incest survivors, including appropriate goals, rules, and boundaries. Herman (1992) has identified the following components of a therapy contract with trauma survivors: the therapist needs to clarify the client and therapist tasks in the therapeutic alliance and the goal of both telling the truth; the therapist also needs careful attention to boundaries in the therapeutic relationship,
including clearly defining the frequency and duration of therapy sessions, clear rules for emergency contact outside of regularly scheduled sessions; and, the therapist needs a clear understanding that the therapy contract precludes any other kind of social relationship. Herman (1992) has stated that these provisions are important because they provide safety for both the client and the therapist. In addition to these provisions, the subjects in this study suggested that additional boundary issues include clear boundaries around the use of touch with incest survivors and disclosure of personal history information. All the subjects highlighted the particular importance of boundary issues with this population, and that in some ways, flexibility is often needed. Herman (1992) has stated that "Because of the requirements for flexibility and boundaries, the therapist can expect repeatedly to feel put on the spot. ... When in doubt, therapists should not hesitate to seek consultation" (p. 151).

c. The principles of transference and countertransference, as well as the specific transference-countertransference dynamics common in treating incest survivors. Therapists would benefit from special attention to the powerful process of projective identification and the ways therapists may experience such relational demands. Awareness of commonly reported roles and countertransferences induced in therapists by incest survivors may help
therapists recognize such countertransferences responses in themselves.

d. The process of human development, with special emphasis on relational and gender differences in development. Training in developmental issues should include the effects of abuse, neglect, and specifically incest, on age-appropriate tasks in the process of human development.

e. The etiology, characteristics of, and treatment strategies for clients presenting with character disorders. Herman (1992) has identified three character disorder diagnoses often given to survivors of childhood trauma: somatization disorder, borderline personality disorder, and multiple personality disorder. One subject stressed the importance of therapist training in the treatment of clients with a "borderline" presentation. Herman (1992) has addressed the commonly discussed link between "borderline" symptoms and chronic childhood trauma, including incest.

f. The continuum of dissociative symptoms and the types of splitting employed as defensive strategies by survivors of childhood trauma, including incest. Therapists would also benefit in training to recognize the many forms of dissociation incest survivors have used to survive. They should also learn to recognize forms of dissociation in themselves, often used to defend against painful client material. Therapists might benefit from workshops in the recognition and treatment of MPD. All of the
subjects in this study treated clients with this diagnosis among their client population. Awareness of the etiology, symptoms, and differentiated treatment recommended for MPD clients may prevent over-diagnosis of this disorder, as well as equip the therapists to seek appropriate supervision or referral.

7. As well as managing the traumatic content, therapists and their supervisors should attend to the many demanding relational process features of treating this population including the impact of clients' projective identifications. Therapists will enhance their effectiveness as they increase their ability to recognize the roles induced by clients and their countertransferences to client projective identifications, understand the client's underlying defensive purposes and use their understanding for empathic, appropriate interventions.

8. Therapists should be prepared for uncertainty as they explore trauma memories with survivors. Herman (1992) has encouraged therapists not to make assumptions about the elements of the story or the meaning given to the trauma by the client. Therapist and client can achieve a mutual understanding of the trauma by carefully exploring all aspects. A desire for certainty can lead therapists to both discount clients' traumatic experiences or to diagnose incest trauma based on a suggestive history of symptoms. In the light of recent concerns about therapists contributing to clients' false memories, care is needed when clients have repressed memories. Herman (1992) has suggested that "both patient and therapist must accept the fact
that they do not have complete knowledge, and they must learn to live with ambiguity while exploring a tolerable pace" (p. 180). The therapist's "role is to be an open-minded, compassionate witness, not a detective" (Herman, 1992, p. 180).

9. As an added buffer, therapists are advised to have a healthy balance and clear boundaries between their therapeutic work and their personal lives. For example, they may find themselves overloaded if their personal lives are also devoted to sexual abuse issues, e.g., with friends or family members. Briere (1989) has suggested that abuse-focused therapists are advised to limit their social contacts with others who treat abuse survivors, lest they devote their social time to talking about victimization. One subject advocated outside activities and even leisure outlets which offer a contrast to sexual abuse-related work.

10. Therapists can offset some of the demands of treating this population by attending to the client balance in their caseloads. As much as is possible, therapists who treat incest survivors should have a mixed caseload, "including some relatively high functioning, non-abused clients" (Briere, 1989, p. 174). Such a balance can remind the therapist that there are parents who do not abuse their children and adult women who do not consider themselves sexual abuse victims. Therapists may be wise to limit the number of clients presenting with very severe histories of abuse.

11. Therapists may find that involvement at the macro level of prevention of sexual abuse or training of other mental health professionals may offer a helpful balance to their therapeutic work.
with clients who have already been victimized (Briere, 1989). One subject in this study (Subject 1) reported that she has enjoyed serving on various social advocacy boards and providing training to other clinicians, which has offered a balance to her demanding caseload.

Limitations of the Study

This study presents data gathered from experienced female therapists' self-reported, retrospective recollections of their responses in treating adult female incest survivors. Such reports and recollections are limited by subjects' abilities to recall experiences over the last 10 years, their ability and motivation to articulate their experiences accurately within the time limits of the interview. The data also depended on the subjects' willingness to disclose information about themselves which may have been sensitive or personally revealing. Although all subjects reported that they felt comfortable with the interviewer and interview questions, there always remains a question about a person's ability to recall and to summarize large amounts of emotionally-laden material heard in the intensity of therapy.

Given the small sample size, the results obtained in this study may not be replicated in subsequent samples of subjects. Given the sample size, that the subjects were social workers, and the small geographical region from which the subjects were drawn, it must be remembered that any generalizations of the results of this study are limited to populations of female therapists who have similar
characteristics to the present sample. The nature of the design and small sample does not provide results which can be generalized to a regional or national populations. One purpose of this study was to stimulate more extensive interest in this topic which would involve larger samples and perhaps permit greater generalization.

Recommendations for Further Studies

This qualitative study has offered findings which support McCann and Pearlman's (1990b) formulation of the process of vicarious traumatization in experienced female outpatient therapists treating adult female survivors of incest. The findings of this study suggest that the cognitive schemas of female therapists may be transformed in both negative and positive directions. The lasting positive transformation or change in female therapists' cognitive schemas was an unexpected finding and one which has not been cited in the literature. The findings have been compared to the current conceptualizations of burnout, countertransference, secondary PTSD, and traumatic countertransference. Out of this study's findings and review of the literature, suggestions have been given for therapists and their supervisors.

The following recommendations and ideas for further studies are offered:

1. When using this structured interview method, providing for a second follow-up interview with subjects would allow for clarification of responses and exploration of relevant issues/themes which may emerge from the first interview.
2. Replication of this study with the following populations would extend understanding of lasting transformation or change in therapists' cognitive schemas as a result of treating incest survivors:

   a. Replication of the study with another sample of experienced female therapist who are psychologists or psychiatric nurses.

   b. Replication of the study with a comparable sample of experienced male therapists.

   c. Replication of this study with an inexperienced sample of female therapists, with 1 or 2 years of experience.

3. A study on the effects of treating incest survivors on therapists' sexual relationships and sexual responses. This area of inquiry was precluded from this study by the guidelines of the university's Human Subjects Institutional Review Board.

4. When the criteria of what constitutes negative and positive lasting change in cognitive schemas have been sufficiently clarified, a larger empirical study with a larger nationally drawn sample testing McCann and Pearlman's (1990b) model of vicarious traumatization would be valuable.
Appendix A

Structured Interview
Structured Interview

Introduction:

Many writers are beginning to address the experiences therapists may have in treating adult survivors of incest. The purpose of my study is to explore the feelings and reactions of experienced female outpatient therapists to treating these clients. Our interview today will explore some of the responses you may have after working with adult female incest survivors over the last ___ years.

Later in the interview, I will also ask you to reflect on whether your experience in treating these clients has prompted any lasting changes in ways that you view yourself, your clients and significant people in your life. By lasting changes I am referring to those response patterns which seem to persist for a year or more.

Do you have any comments or questions on this before we go on?

As you talk about your experiences, I’d like you to feel free to talk to the extent or depth that you are comfortable on any of the questions. If any question seems unclear to you, please ask for any clarification you need. You are free to pass on any of the questions without giving an explanation. You are also free to stop the interview at any time.

Any questions on any of this before we begin?

Interview Questions:

1. As you listen to the stories of adult female incest survivors, what feelings and reactions do you usually have?

2 a) After your ___ years experience with these clients, are there any aspects of treating adult female incest survivors that you find personally demanding?

2 b) If you think back to when you first began treating these clients, were there any aspects of treating adult female incest survivors that you found personally demanding for you then?

2 c) Do you find that there is anything unique in treating this client population compared to other populations you have worked with?
In the next series of questions, I’m going to describe some of the basic beliefs or assumptions people often have about themselves or other people. For each basic belief, I’ll describe the belief and ask you a few questions, exploring whether your experience treating adult female incest survivors has prompted any lasting changes for you. By lasting changes I am referring to those response patterns which seem to persist for a year or more.

In each area, I’ll be asking you to reflect on whether treating this population has prompted any lasting changes in your expectations, assumptions or beliefs in that area first for yourself; second, your expectations about your clients.

Any questions on this before we continue?

3. a) The first basic belief has to do with safety. Please reflect on your beliefs having to do with your safety, or feeling reasonably invulnerable from harm. As a result of your experience treating adult female incest survivors, have you noticed any lasting changes in yourself in your sense of feeling safe, or of feeling reasonably invulnerable to harm?

Prompts: Tell me about them.

How long have you noticed this change?
Do you experience this change as negative? Positive?

3 b) Also in the area of safety, as a result of treating this population, have you noticed any lasting changes in your belief that your clients can be safe, in your sense that they can be reasonably invulnerable to harm?

4. a) Please reflect on your beliefs about trust, having to do with believing what others tell you, trusting others and depending on others to meet your needs. As a result of your experience treating adult female incest survivors over the last ....years, have you noticed any lasting changes in yourself about your sense that you can believe what others tell you, trust others and depend on others to meet your needs?

4 b) Again in the area of trust, as a result of treating this population, have you noticed any lasting changes in your belief that your clients can believe what others tell them, trust others and depend on others to meet their needs?
5-1-a) Please reflect on your beliefs about esteem, believing that you can be valued and validated by others. As a result of treating adult female incest survivors, have you noticed any lasting changes in your belief that you can be valued and validated by others.

5-1-b) Again in the area of esteem, as a result of treating this client population, have you noticed any lasting changes in your beliefs that your clients can be valued and validated by others?

5-2-a) Please reflect on esteem another way, about your beliefs in the benevolence of others and that they are worthy of respect. As a result of treating adult female incest survivors, have you noticed any lasting changes in your belief in the benevolence of others, of human beings, and that they are worthy of respect?

5-2-b) Also in the area of esteem, as a result of treating this population, have you noticed any lasting changes in your belief that your clients can expect others to be benevolent and worthy of respect?

6 a) Please reflect on your beliefs about independence, having to do with freedom, independence and the freedom to make your own choices. As a result of treating adult female incest survivors have you noticed any lasting changes in yourself in your beliefs about your freedom, independence and ability to make your own choices?

6 b) Again in the area of independence, as a result of working with this client population, have you noticed any lasting changes in your belief that your clients can have freedom, independence and ability to make their own choices?

7 a) Please reflect on your beliefs about power, having to do with having control in your life, in your ability to impact others, and have an impact in the world. As a result of treating adult female incest survivors, have you noticed any lasting changes in your beliefs about having control in your life, in your ability to impact others, and your belief that you can have an impact in the world?

7 b) Again in the area of power, as a result of treating adult female incest survivors, have you noticed any lasting changes in your belief that your clients can have control in their lives, can impact others and can have an impact in the world?
8 a) Please reflect on the area of intimacy and connectedness, of the ability to feel connected to others like colleagues, family or friends and belonging to a larger community. As a result of your work with adult female incest survivors have you noticed any lasting changes in your sense of feeling connected to others like colleagues, family or friends and belonging to a larger community?

8 b) Again in the area of intimacy, as a result of your work with this population, have you noticed any lasting changes in your beliefs that your clients can feel connected to others and belong to a larger community?

9. Many people believe in a world which is meaningful, just and fairly predictable as part of their frame of reference. This is an example of one frame of reference. Please reflect on your frame of reference. After treating adult female incest survivors for ____ years, have you noticed any lasting changes in your overall frame of reference or your way of making sense of life's experiences?

Prompts: Please tell me about them. Please say some more about this.

10. Please reflect on your basic beliefs as they relate to those you care about like a partner, family members, or children. Have any of your basic beliefs (regarding safety, trust, independence, intimacy, power or esteem), about those you care about been changed in lasting ways as a result of treating this client population?

11 In your ____ years of experience treating this population you’ve probably had numerous powerful experiences. Have you had any especially especially powerful or striking experiences in treating adult female incest survivors that come to mind that you wish to talk about?

Prompts: Tell me about them?

How has this experience (s) affected you?

12. Have you noticed that treating adult female incest survivors ever prompts any strong physical reactions in you?

Prompts: Tell me about your experience of this.

What is this like for you?

13. Have you noticed that treating this population ever influences your dreams or daytime images?

Prompt: Tell me about your experience of this.
14. Have you noticed that these clients position you or place you psychologically in any particular roles?
   Explanation: For example, many kinds of clients might try to position the therapist in a parental role.
   Prompt: Tell me what this is like for you.

15a) What are the most effective ways that you use to help you deal with the challenges of treating this client population? I would like to hear about any professional and personal ways that you wish to share.

15 b) If you think about a new therapist beginning to treat this population, what suggestions do you have for such therapists, both professionally and personally?

16. Do you believe there is any relationship between being female and the particular impact this work has on you?

17. Is there anything else in your work with this population you wish to talk about?

18. How has it been for you to answer these questions?
Appendix B

Therapist Background
Therapist Background

1. Name__________________________________________

   Work address_________________________ Zip Code ______

2. Age ______ 3. Degree________________________________

4. Years of experience
   a) Length of time you have worked as a therapist: ________ years
   b) Length of time you have treated incest survivors in outpatient settings: ____________ years

5. Caseload:
   a) Number of clients seen per week on average:___________
   b) Over the last 8 years what percent (approx) of your caseload has been composed of adult female incest survivors:

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On the following questions, check any that apply
6. Supervision or consultation used:
   a) Type: Individual ______ Peer ____________ Other __________________
   b) Frequency: Weekly _____
                  Monthly ______
                  As needed ______
                 Other ______________

7. Training/education in the treatment of incest survivors:
   a) Coursework_____________
   b) Workshops _____________
   c) Books__________________
   d) Other__________________

Please return this completed form to:
Marcia Hollingsworth, M.A., L.L.P.
2123 Godwin Street,
Grand Rapids, MI 49507

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Appendix C

Letter to Therapists
August, 1992

Dear

Would you be willing to participate in a research project exploring the experiences, feelings and reactions of female therapists to treating adult female survivors of incest?

I am conducting research on this topic for my doctoral dissertation through the Counselor Education and Counseling Psychology Department at Western Michigan University. The research project has been approved by Western's Human Subjects Institutional Review Board.

I am looking for experienced female therapists who are willing to be interviewed about their experience treating adult female incest survivors.

I am looking for female therapists who meet the following profile:
- have a master's level training, e.g. M.A., M.S.W., M.S.
- have 8 years or more experience as an outpatient therapist treating adult female incest survivors
- currently have adult female incest survivors on their outpatient caseload.
- are willing to participate in an interview for about two hours about their experiences in treating adult female incest survivors

If you are willing to be interviewed, would you:
1) Complete the enclosed Therapist Background form
2) Sign two copies of the enclosed Informed Consent form and keep one copy.
3) Return the Therapist Background form and one copy of the Informed Consent form to me in the enclosed envelope.

One female therapist per agency or private practice will be randomly selected. Confidentiality of information and privacy of subjects will be maintained throughout the research project. If you have any questions about this research project and the interview, you may contact me at my home or office.

Thank you for considering this research project.

Sincerely,

Marcia Hollingsworth, M.A., L.L.P.
2123 Godwin St. S.E.,
Grand Rapids, MI 49507
Home: 245-8760; Office: 241-6767

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Appendix D

Informed Consent
Appendix D
Informed Consent

This is a study of the self-reported experience of female outpatient therapists in treating adult female survivors of incest. It will explore what female therapists report are some of the personally demanding features of treating this client population. It will also explore whether female therapists have experienced any lasting changes in the ways they view themselves, their clients and significant people in their lives, resulting from treating incest survivors. Hopefully, this study will add to the understanding of the impact that these clients have on female therapists, as well as some suggestions for treatment and further research.

Your participation will require about two hours. In an interview with Marcia Hollingsworth, M.A. you will be asked to respond to a series of questions about your experience as therapist with adult female survivors of incest. This opportunity may offer you the benefit of reviewing some of your experiences in treating this client population, and making a contribution to a study of the impact of treating incest survivors on their female therapists.

The interview will be audiotaped and transcribed for data analysis. You will not be identified on the written copy. Tapes and any identifying information will be stored in a locked cabinet in the researcher's home. All tapes will be destroyed when the research project is completed.

The background information you supply will be used for screening and statistical purposes only. At no time during or after the study will anyone be able to identify you.

Because of the nature of the research, certain criteria must be met for participation in this study, and random selection will be used. If selected for an interview, you will be contacted within three weeks of receipt of the
Informed Consent and Therapist Background forms. The number of participants in this study will not exceed ten.

Your participation is voluntary. If you should feel uncomfortable about any aspect of your participation, you may discontinue at any time. If you have any questions about the procedures of the study you may ask me to answer them at any time. During the interview, you are free to respond on any question to the extent and depth that is comfortable. You are free not to respond to any question(s), without explanation.

The researcher expects that the risks or discomfort for participating in the interview will be minimal. In the unlikely event that any discomfort persists, please contact me to discuss appropriate ways to deal with this.

Results of this study will be available upon request.

Thank you for your consideration of this study.

Marcia Hollingsworth, MA.  
2123 Godwin St. S.E.  
Grand Rapids, MI 49507  
Home: 245-8760  
Office: 241-6767

Edward L. Trembley, D.Ed.,  
Professor, CECP, and Licensed Psychologist  
Doctoral Advisor for Ms. Hollingsworth  
Office: 387-5115

Please sign two copies of the Informed Consent form and keep one for your records. Return one copy to Marcia Hollingsworth (address above).

I have read and understood the above statement and agree to participate in this study.  
Name ____________________________________________

Address ____________________________________________

Signature ____________________________________________

Date: ____________  
_______ I would like a copy of the research results sent to me.
Appendix E

Unique Coding System
UNIQUE CODING SYSTEM

In developing the unique coding system, subject responses were considered only to the questions in a particular cognitive schema. Although a subject may have given a response elsewhere in her narrative which demonstrated lasting change in other schemas, these were not identified and coded. The intent of this document is to give one typical sample of language demonstrating lasting change where such were found in response to a particular schema question.

General Criteria:
1. **No Change - 0** represents a response which does not demonstrate lasting change in a cognitive schema as a result of treating adult female incest survivors. A response in a codeable unit will be coded 0 if it meets any of the following conditions.
   a) If the subject states that she has not experienced a change in that particular cognitive schema.
   b) If her earlier beliefs have remained the same or been reinforced in some way.
   c) If she has experienced a lasting change but does not attribute the change to working with adult female incest survivors.
   d) If she does not in some specific way attribute a lasting change to working with this population.

2. **Lasting change - negative: LC -** represents a response which demonstrates a lasting change in a negative direction in a cognitive schema as a result of treating adult female incest survivors. A response in a codeable unit will be coded LC - if it meets any of the specific conditions below and/or any of the following general conditions:
   a) If the subject states that her beliefs have weakened in some way.
   b) If the subject states that she has become more cautious in some way.

3. **Lasting change - positive: LC +** represents a response which demonstrates a lasting change in a positive direction in a cognitive schema as a result of treating adult female incest survivors. A response in a codeable unit will be coded LC + if it meets any of the specific conditions below and/or any of the following general conditions:
   a) If the subject states that her beliefs have strengthened, grown, or been enhanced in some way.

Specific Criteria:
A codeable unit will be coded as demonstrating lasting change-negative (LC-) or lasting change positive (LC+) if the response meets any of the following criteria specific to each of the cognitive schema listed below.
Criteria for Cognitive Schemas

1. SAFETY: The need to feel safe and reasonably invulnerable to harm, (McCann & Pearlman, 1990a).

A. Lasting Change - Negative (about self, clients or significant others):

1) Any sense of loss of safety, including the following:

A) Any statements conveying a sense of being more vulnerable (McCann & Pearlman, 1990b)

   Self: "I am ... much more aware of how I could be on the receiving end, and aware that my clients' families could retaliate at me at any point in time ...."

   Clients: "[this work] has made me less sure that my clients can be safe . . . ."

   Significant others: "I worry about my child's safety more than I would have before."

   "I have very few illusions as far as if someone said my husband has molested someone. I wouldn't get into orbit about that. I would think, 'Well, let's find out about that. . . .'. Because nothing is impossible. . . ."

B) Any statements conveying a sense of being more vigilant, (McCann & Pearlman, 1990b)

   Self: "I am more careful [about my safety]."

   Significant others: "I'm real sensitive to teaching them [her children] safety and helping them honor their bodies, or having other people respect their body, beyond sexuality."

   (From Pilot)

C) Any statements conveying a sense of being paranoid, (McCann & Pearlman, 1990b)

   Self: "I am much more paranoid. . . ."

   Significant others: "I am more suspicious of the motivations of people towards my children."

2) Any images of being victimized, associated with personal vulnerability (McCann & Pearlman, 1990b).

   Self: "... early on ... I could have scary dreams of my personal safety. . . ."

3) Any statements indicating that being more cautious of one's sense of safety, and/or taking precautions to assure one's safety (McCann & Pearlman, 1990b).

   Self: "I'm much more cautious about my own sense of safety, and made it a point to take courses that have challenged me to protect myself . . . [ropes courses, self-defense courses]"

   (From Pilot)
Significant others: ". . . . my sense of protectiveness about my children is greater than it would otherwise be. I am much more apt to be talking to them about . . . making sure they aren't molested. . . ."

4) Any statements indicating any heightened sense of vulnerability or any movement toward feeling more vulnerable (McCann & Pearlman, 1990b).

Clients: "At the beginning [I did] not give as much credence to how vulnerable we really are as human beings. . . ."

5) Any statements indicating an enhanced awareness of the fragility of life (McCann & Pearlman, 1990b).
Self: "I am much more aware of how indiscriminate evil can be, the choices people make in terms of how they behave."

B. Lasting Change - Positive (about self, clients or significant others):
1) Any statements indicating that one feels more safe.
Self: "I feel more safe now than I used to . . . my work [with this population] is growth producing. . . ."
Clients: "I believe that people have the capacity to be more safe than they think they can be."

Significant others: " . . . it has made me more cognizant . . . more attentive to [safety of friends or children of friends] . . . . that people can be safe and can move in a more positive direction."

2) Any statements indicating feeling less fearful.
Self: "I would see myself as less fearful than I used to be."

Clients: "I've been able to accept that my client will be O.K., to where before I would get overwhelmed. . . . I [am] able to credit my clients with having more of the strength than I think at first I thought that they could not possibly have had after telling me all that stuff. (From Pilot)"

3) Any statements indicating feeling less vulnerable to harm.
Clients: "I work hard to . . . [help clients] understand that the world is a safe place now, that the rules have changed."

2. DEPENDENCY/TRUST: the need to believe in the word of others and depend on others to meet one's needs (McCann & Pearlman, 1990a).

A. Lasting Change - Negative (regarding self, clients or significant others):
1) Any statements indicating being suspicious of people's motives (McCann & Pearlman, 1990b).
Self: "I've been continually reminded of how much people can abuse trust... I basically don't think you can take too much for face value."

2) Any statements indicating being more cynical (McCann & Pearlman, 1990b)
   Self: "... families are largely screwed up more of the time than not... not much surprises me."

3) Any statements indicating being more distrustful or expecting the worst of people (McCann & Pearlman, 1990b).
   Self: "I have less trust over these years, and don't expect people are telling me the truth as I used to."
   Clients: "I have less belief that they [clients] can trust and depend on others to meet their needs..."

4) Any statements indicating a change from believing that most people are trustworthy toward most are not trustworthy (McCann & Pearlman, 1990b).
   Clients: "I was more unrealistic when first working with my clients, [earlier uses word 'Pollyanna'], that there would be people out there who would be real sympathetic, real empathetic, and very supportive, not really realizing that the other people that they're close to might have their own issues... A lot of my clients gravitate toward other victims..." (From Pilot)

B. Lasting Change - Positive (about self, clients or significant others):

1) Any statements indicating feeling more trusting of others.
   Self and clients: "as the therapy process continues, eventually the core issue will be clear to me and to the client, and all the pieces of the story don't really matter so much... [says she tells clients that] 'you may get the pieces and you may not, and if they're there you will get them when you're ready to get them.' -- that base of permission and giving them trust in themselves, and me trusting that whatever they have is whatever they have. ..." (From Pilot)

2) Any statements indicating an increased optimism that others can meet one's needs.
   No evidence of this was found.

3) Any statement expressing an increased sense that one can believe the word of others and/or depend on others to meet their needs.
   Self: "I ask more directly for what I want and what I need... I am less co-dependent with people... I am less inclined to take care of someone." (From Pilot)
3. ESTEEM: the need to be valued and validated by others (McCann & Pearlman, 1990a) and the need to view others as benevolent and worthy of respect (McCann & Pearlman, 1990b).

1) That the therapist is valued and validated by others.
(McCann and Pearlman, [1990b] do not address this facet of esteem in their article on vicarious traumatization)

A. Lasting Change - Negative (about self, clients or significant others):

*Any statements indicating a diminished sense that they can be valued and validated by others, or respected by others.
No statements of this were found.

B. Lasting Change - Positive (about self, clients or significant others):

*Any statements indicating an increased sense that they can be valued and validated by others.

Self: "There's an increased sense that I can be valuable and be valued by others, because I have seen the impact that I've made on these people."

Clients: "I certainly have a sense that they can be much more valued by others... I've become more and more convinced of this... it's been a growing conviction."

2) That others are benevolent and worthy of respect
A. Lasting Change - Negative (regarding self, clients or significant others):

1) Any statements expressing a more cynical or pessimistic view of human nature (McCann & Pearlman, 1990b).
No Statements of this were found.

2) Any statements indicating a movement from a more idealistic view of human nature to a shattering of one's belief system, or one acknowledging the terrible abuses people perpetrate on others, (McCann & Pearlman, 1990b).

Self: "There's been a decrease in that definitely... I'm just wiser... through listening to experiences of these people who... were abused by others who look like pretty fine respectable people."

3) Any statements indicating a diminished view of human nature, associated with feelings of bitterness, cynicism or pessimism (McCann & Pearlman, 1990b).
No statements of this were found.

4) Any statements conveying a sense of anger at other people or the
world in general as they reflect on the potential malevolence of others (McCann & Pearlman, 1990b).
   No statements of this were found.

5) Any statements "on an existential level, ... reflecting on the problem of human perversity and pondering the fate of the human race" (McCann & Pearlman, 1990b, p. 140).
   No statements of this were found.

B. Lasting Change - Positive (about self, clients or significant others):
   1) Any statements indicating an enhanced or more positive view of human nature.
      No statements of this were found.
   2) Any statements indicating enhanced beliefs in the benevolence of others.
      No statements of this were found.
   3) Any statements indicating enhanced beliefs that people are more worthy of respect.
      Clients: "It's ... enhanced that [that clients can expect others to be benevolent and worthy of respect] somehow. ... I'm sure that's part of why I'm in this business, but enhanced."

4. INDEPENDENCE: the need to be able to have freedom to make one's own choices, to control one's own behavior and rewards (McCann & Pearlman, 1990a).

A. Lasting Change - Negative (regarding self, clients or significant others)
   1) Any statements indicating concern about loss of independence or personal autonomy (McCann & Pearlman, 1990b).
      No statements of this were found.
   2) Any identification with a client's loss of control or freedom, (McCann & Pearlman, 1990b).
      No statements of this were found.
   3) Any statements expressing concern about losing sense of personal control and freedom in one's life (McCann & Pearlman, 1990b).
      No statements of this were found.
   4) Dreams of being trapped and confined (McCann & Pearlman, 1990b).
      No statements of this were found.
   5) Any statements indicating an increased sense of personal vulnerability (McCann & Pearlman, 1990b).
      No statements of this were found.
B. Lasting Change – Positive (about self, clients or significant others):

1) Any statements conveying feeling more independent as a person.
   Self: I'm perhaps more independent that I may have been initially . . . I believe that has come from helping people, teaching people, these women about their individual capabilities and again that self-empowerment, that self-esteem. I can't imagine not teaching that and not growing from that." (From Pilot)

2) Any statements conveying feeling greater freedom to make her own choices.
   Self: "so the sense of independence in the sense that you are not forever . . . bound by your experience . . . it has had an impact, positive, I mean growth producing impact for me . . . I'm sure."
   Clients: [Said that she has moved to position of recognizing their freedom of how far they want to go in the therapy process] "honoring their choices about not doing it [working on a goal] and let's look at 'how come.' . . . this has been more of a challenge for me . . . when a client chooses not to pursue the healing process as I might see it." (From Pilot)
   Significant others: "Not that they have the freedom, but that they're more capable [earlier says that has changed for her]. So understanding what they need to do, that they can be independent people. It's O.K. to get their needs met has been more acceptable in the last couple years." (From Pilot)

3) Any statements conveying an increased sense of having control over one's choices or behavior.
   Clients: [Says she has learned that] "they've got this far on their own. They're going to know a lot more than I'm going to know about how far they can push . . . I've been able to appreciate and respect . . . their need to be able to take over their own lives and not have someone come in to rescue." (From Pilot)

5. POWER: the need to exert control over others and one's life, (McCann & Pearlman, 1990a).

A. Lasting Change – Negative (regarding self, clients or significant others):

1) Any statements regarding being very impacted by the powerlessness of their clients (McCann & Pearlman, 1990b).
   No statements of this were found.
2) Any statements which suggest that they have urged clients inappropriately to take action rather than help clients understand the meaning of their responses (McCann & Pearlman, 1990b).
   No statements of this were found.

3) Reporting that they are (have) taken self-defense courses (McCann & Pearlman, 1990b).
   Self: "I . . . have made it a point to take courses that have challenged me to protect myself, whether it be ropes courses or self-defense courses." (From Pilot)

4) Reporting that they have become more dominant in social or work situations (McCann & Pearlman, 1990b).
   No statements of this were found.

5) Fantasies on how one would protect one's family or self from victimization (McCann & Pearlman, 1990b).
   No statements of this were found.

6) Fantasies that are brutal or retaliatory, designed to reaffirm beliefs in one's personal power (McCann & Pearlman, 1990b).
   No statements of this were found.

7) Any statements conveying a heightened awareness "of the illusory nature of control over capricious or unexpected life events" (McCann & Pearlman, 1990b, p. 139).
   Self: "I have to come and say, I could walk outside right now and have a tree branch fall on me or an airplane . . . could snuff us out . . . I try to . . . realize what the realities are so we don't continue feeling like a victim. . . . We have to realize that there is always the possibility of the randomness of the world." (From Pilot)

8) Any expressions of helplessness, depression or despair about uncontrollable forces of human nature (McCann & Pearlman, 1990b).
   No statements of this were found.

B. Lasting Change - Positive (about self, clients or significant others):

1) Any statements conveying having more impact in the world and/or on others.
   Self: "Now I feel empowered and that I can have an impact, feel that I am capable, and feel that I don't have to fight for it. [Earlier stated] when I first began I didn't feel that I had a lot to offer, I didn't feel that I knew what I was doing".

   Clients: "how they [clients] can still go back and confront . . . people within their system . . . and do life differently, have a healthier relationship with people. . . . There's just a continual impact." (From Pilot)
2) Any statements conveying a sense of having more control in one's life.

   Clients: "how they choose not to take a certain job, how they're willing to ask questions that will red flag them... Confronting their partners about like this or not like this, or... not continuing their abusive relationships with their kids." (From Pilot)

3) Any statements conveying beliefs that one feels more powerful.

   Self: "Yes... quantifying how much that's grown is a little difficult... I think that working with a population where that's often the focus... being able to experience their own sense of power and not powerlessness or helplessness. I'm sure that's rubbed off.

   Clients: "Their power is what's important and not mine... A goal of treatment is for them to experience that... I'm probably further than I used to be and in a good place with it... I think the word optimism comes to mind—the sense that people can move on."

6. INTIMACY/CONNECTEDNESS: the need to feel connected to others through individual relationships and to a larger community (McCann & Pearlmân, 1990a)

A. Lasting Change - Negative (regarding self, clients or significant others):

1) Any statement voicing a sense of alienation from others, (McCann & Pearlmân, 1990b).

   No statements of this were found.

2) Any statements conveying a distancing or sense of separateness from colleagues, family or friends who do not understand the nature/demands of the work (McCann & Pearlmân, 1990b).

   Self: "If you attempt to [talk with a spouse] it was so unnerving and upsetting for him because he had not gone through the period of desensitization that I had... So you're left alone with that knowledge and that was difficult and isolating."

   Self: "it has made me somewhat impatient with people who have a more simplistic view... It sometimes makes me feel more isolated in my views when I get into a group of people who are less experienced to the world of sexual abuse."

3) Any statements voicing feelings of being stigmatized by working with this population, e.g. other professionals assuming that the therapist chose this population because of her own unresolved conflicts (McCann & Pearlmân, 1990b).

   No statements of this were found.

4) Any statements voicing that keeping confidentiality interferes/impedes connectedness with others (colleagues, family) (McCann & Pearlmân, 1990b).

   Self: "you're trying to protect the confidentiality of your..."
client. You may have just heard how people were murdered—something that is just beyond your normal experience, and you really can't talk with anyone about that."

5) Any statements conveying a diminished sense of connection to others.

Self: "it's such powerful and creative work that it could obliterate other connections or time for other connections. . . . You need sort of a decompression time, and that then impacts how you connect to your family and to your friends."

Clients: "the level of scarring is so significant that they won't ever be as connected as I would hope for them to be. I would have been more optimistic initially, you know--'we'll fix this and everything will be O.K.' . . . I have a sense that they will be more brittle."

B. Lasting Change - Positive (about self, clients or significant others):

1) Any statements conveying a sense of greater sense of intimacy.

Self: "My sense is that it is positive . . . I feel more comfortable in my life, not only in experiences with myself, but in general of having that kind of interaction and relationship with people."

Clients: "Each time they [clients] break their secret, each time they tell their story, it's an 'in-to-me-see.' That's how I look at intimacy. . . . It's like 'look into me further' (From Pilot)

2) Any statements indicating feeling more connected to colleagues, family or friends.

Self: "that has increased, the sense that we're kind of in this together with other therapists, and a real compassion for the clients as well as other therapists, and a sense of connection."

Clients: "their ability to be connected is rather amazing when you see how isolated they have been. So I'd say it's an increased sense of their ability to be connected to others."

Significant others: "my attitudes towards . . . my family, the preciousness of my children, my gratitude towards my parents for not . . . being sexually abused myself is very pronounced."

7. FRAME OF REFERENCE: "the need to develop a stable and coherent framework for understanding one's experience (McCann & Pearlman, 1990a, p. 23).

A. Lasting Change - Negative (regarding self)

1) Any statement about trying to understand why a traumatic event happened or a therapist trying to assign causality—e.g., blaming the
victim (McCann & Pearlman, 1990b).

Self: "Where unbelievable things have been shared, part of me will just go, 'Why?!' I try to put things back [to my model], trying to understand . . . what is adaptive about these kinds of behaviors being in place?

2) Reporting a sense of disorientation or an unsettling sense of uneasiness (McCann & Pearlman, 1990b).

No statements of this were found.

3) Any statement conveying more awareness of evil, or an expanded sense of evil.

Self: "I'm going to sound cynical. There are some pretty nasty . . . a very few evil people and there's the rest, very misguided, or whatever. But there are some people that are just absolutely awful - the more I hear about perpetrators, and they get away with it." (From Pilot)

4) Any statement conveying more awareness that life is not fair or just.

Self: "Working with incest survivors has shaken it [her frame of reference] to some extent, because these things are so capricious, and . . . just kind of seem to happen and then more bad things happen on top of that. It's discouraging."

Clients: "[I am] more aware that I can't guarantee to my clients that if you do this, this and this, that everything wonderful is going to happen. There is no guarantee, so less of the Pollyanna . . . I'm more of a realist with what this world is and it isn't fair." (From Pilot)

5) Any statement conveying more awareness of the prevalence of incest and other forms of abuse.

Self: "I don't think my world view has been shaken, except to expand the number of people obviously that are in the world that choose to do evil acts, and to do things that I wouldn't have thought could be done [exhales audibly]."

6) Any statement indicating a negative change in their frame of reference.

Self: "it has [with emphasis in her voice] really taken away any sense that this is a loving world . . . I still believe that in specific instances, but not in the big picture."

B. Lasting Change Positive (about self, clients or significant others):

1) Any statements conveying a sense of a more stable or coherent framework for understanding one's work and experiences.

No statements of this were found.
2) Any statements conveying a stronger sense that life is fair or just.
   No statements of this were found.

3) Any statements conveying a stronger sense in the power of love and affirmation.
   No statements of this were found.
Appendix F

Human Subjects Institutional Review Board Approval
Date: July 7, 1992
To: Marcia Hollingsworth
From: Mary Anne Bunda, Chair
Re: HSIRB Project Number: 92-07-03

This letter will serve as confirmation that your research protocol, "Responses of Female Therapists to Treating Female Adult Survivors of Incest" has been approved under the exempt category of review by the HSIRB. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the approval application.

You must seek reapproval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date.

The Board wishes you success in the pursuit of your research goals.

xc: Trembley, CECP

Approval Termination: July 7, 1993
BIBLIOGRAPHY


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