4

Her-story in the making:

Therapy with women who were sexually abused in childhood[1]

by
Amanda Kamsler[2]

This chapter discusses some of the problematic aspects of the 'traditional' cultural stories about:

- the long-term effects on women of child sexual assault, and
- therapy approaches for working with these women when they identify difficulties in their lives.

Some alternative ideas are outlined about how a therapist can participate

with women clients who experienced sexual assault in childhood, to enable them to go beyond the oppression of the dominant, pathologising stories they have about themselves (e.g. stories in which they see themselves as damaged for life), so that they may begin to have access to new, empowering stories about their own resourcefulness and survival. Knowledge gathered from women's stories of their experiences demonstrates how a therapy process that assists clients to locate their experiences in new stories about their resourcefulness leads to them finding and evolving new possibilities for their lives.

Over the last few years I have worked as a therapist in Sydney, Australia, with a number of women who were referred to my practice saying that they were experiencing difficulties which they believed to be related to childhood experiences of sexual assault by male family members or acquaintances. I also work as a consultant for Dympna House, an incest counselling and resource centre for families in which children have been sexually assaulted, and for women who were sexually assaulted in childhood. These experiences have challenged me to re-evaluate my thinking about child sexual assault and to establish clearer ideas about ways of working with the women I see. Ideas outlined in this chapter illustrate some examples from my work and show some applications of these ideas.

For the purposes of this discussion, I propose the following definitions of child sexual assault and incest:

> *Child sexual assault is a sexual act imposed on a young person or child by another person (usually male). The ability to engage a child in a sexual relationship is based on the all-powerful and dominant position of the adult (or older adolescent) offender, which is in sharp contrast to the child's age, dependency, and powerlessness. Authority and power enable the perpetrator to coerce the child into sexual compliance.*
>
> *Incest is any sexual act imposed on a young person or child by another person (again usually a male), taking advantage of his position of power and trust within the family. 'Family' can mean natural parents, step-parents, grandfathers, uncles, brothers, and so on.*[3]

Themes in the literature about the long-term effects on

women of child sexual assault

A predominant theme in the literature about the effects of child sexual assault is the notion of psychological damage, which the child undergoes as a result of being sexually assaulted, and which leaves them with long-term impairments and deficits in their personality. Some writers, such as Ellenson (1985), are interested in identifying these women as having a 'syndrome', describing a set of personality variables commonly manifested by women who were sexually abused as children. These writers propose that the behaviour of women may be assessed using certain criteria from traditional psychiatry. These criteria are used to discuss the 'syndrome', so that doctors and others might diagnose the level of disturbance of the women. Blake-White & Kline (1985) have identified the women's symptoms as fitting with the DSMIII category of post-traumatic stress disorder: *Women who experienced incest as a child have the same pattern of symptoms that identify the syndrome* (p.396).

They, and other writers in the field, focus on the 'dissociation process', or the 'repression of emotion' which they observe in women who experienced sexual assault in their childhood. Shapiro (1987) holds the view that the woman's ego is 'shattered' and will require 'rebuilding' after such experiences, and this is another common theme in the literature.

Thus the emphasis of many writers has been on the use of traditional psychiatric classification practices to understand and deal with women's responses to child sexual assault. These ideas have had profound implications for the development of ideas about how therapy should be conducted. The goals of therapy have been described in terms like *helping clients get in touch with repressed emotion; working through feelings; dealing with repressed memories* (Blake-White & Kline 1985, p.398 & 399); and *working through painful experiences and the accompanying guilt and shame, so that conflicts can be revealed, understood, and resolved* (Faria & Belohlavek 1984, p.469). The act of helping clients to understand the meaning of repressed conflicts is said to produce change. The client comes to terms with her repressed feelings, and this leads to changes in behaviour. Overall, the terms used to describe approaches to therapy imply that they are based on ideas about diagnosing the client's pathology, which will then be treated by the therapist.

In applying this framework in therapy, the context for the development

of the woman's problems is not considered. The attention of therapists has been focussed on ideas like the 'seductive child', or 'pathological mother'. A significant effect of this individual pathology focus is that therapists may overlook the contribution of the perpetrator's interactions with the woman to the development of her perceptions about herself and the world. This effect is understandable in view of the way that the psychiatric literature about incest has largely referred to psychodynamic theory. In the literature, blame has been shifted away from the perpetrators and onto the victims. Waldby (1987) and Ward (1984) provide a clear discussion of the historical origins of this shifting of blame. Elizabeth Ward refers to the clinical literature on incest and finds 'stunning testimony' to what feminist theorists Stanley & Daly have named 'agent deletion'. She describes how the language used in the literature *subliminally establishes the wives and daughters as the active parties and the fathers as passive puppets* (p.134). Her extensive discussion contains graphic examples from the clinical literature which are *couched within a cobweb of the same old blame-the-victim mythology* (p.157).

The literature from family psychiatry offers another set of themes about ways of considering the long-term effects on women of child sexual abuse. This body of theory proposes that family dysfunction is the explanation for the existence of incest. The family as a unit is seen as pathological, and symptoms signify overall current family maladjustment. The dysfunctional incestuous family is one in which 'normal' family hierarchies based on age and sex have broken down. This breakdown is attributed almost completely to mothers who are frequently seen as failing to fulfil their nurturing and protective roles toward the children and their wifely role to the father (Lustig et al. 1966; Justice & Justice 1979).

Pathological relationships are viewed as the therapeutic issue, and the occurrence of incest is perceived as a symptom of this. Incest is seen as serving the function of holding together a family system whose internal relationships are unstable: *We propose that incest is a transaction which serves to protect and maintain the family in which it occurs* (Lustig et al. 1966, p.39).

Furniss (1983) supports the idea that incest is a symptom of family dysfunction, saying that: *the development of the incest dyad between father and daughter is strongly influenced by problems in the mother-daughter and mother-father dyad* (p.267).

His discussion of the father-daughter dyad focusses mainly on the daughter's contribution, and his discussion of the mother-daughter dyad focusses mainly on the mother. It is notable that the perpetrator's contribution is only briefly mentioned (Calvert 1984). McCarthy & Byrne (1988) recently made the following statement when commenting on their hypothesis about the link between 'ambivalent social relations' and the generation of incest:

> *… it seems as if the increased occurrence and disclosure of father-daughter incest is a 'socially situated' phenomenon reflecting the confusion at the heart of the modern family. It is an apparent paradox that this phenomenon is a particular family's somatic expression of its struggle to be child-centred, to shift its gender roles, and to value emotionality, proximity, and non-hierarchical social relations.* (p.183)

Once again, the significance of the father's behaviour is obscured in this statement.

Concepts from family therapy such as the view that incest serves a function for the family, or that it may be a family defence against loss (Gutheil & Avery 1977), suggest particular directions for therapy of adult women who experienced child sexual abuse. Therapists operating from these points of view will focus on assisting women to become more 'functional' according to certain criteria for 'normal' family relationships. For example, Deighton & McPeek (1985) describe a family of origin treatment approach in which women in a group are coached to develop a more objective stance with family members and to resolve interpersonal issues with them. They write about the benefit of this being that women begin to see *that the adult perpetrator and the non-involved parent were victims too* (p.408). The authors emphasise the *responsibility of the woman in changing her position relative to family of origin members* (p.410).

These ideas about family dysfunction all obscure the operation of power relationships implicit in incest, and serve to protect the perpetrator and de-emphasise his responsibility. Waldby (1987) says that: *the daughter's experience is effectively denied by this therapeutic focus, which regards the actual incestuous relationship as a red herring, whose pursuit may actually impede treatment* (p.15).

In emphasising the idea that family dynamics should be the focus for therapy, rather than the incest itself (e.g. Machotka 1967), many authors

suggest that therapists working with families where incest has occurred assign responsibility to all family members as if they are equally culpable. They see any strong focus on the role of fathers as inappropriate. Thus, therapy based on these notions involves members having to adjust their behaviour to more appropriate roles - particularly, it seems, the traditional roles of mother and daughter.

Thus, while these therapeutic approaches acknowledge the importance of the family context for the development of the woman's problems, they do so in a way which, once again, obscures the power relationship the perpetrator had in his interactions with her in childhood. I believe that these frameworks for therapy promote blindness (or, at best, insufficient attention) on the part of the therapist to the responsibility of the perpetrator in shaping the woman's responses and future. As with frameworks which rest on ideas of pathology and diagnosis, the significance of the broader social context is ignored or glossed over in descriptions about these approaches to therapy.

An alternative view

I agree with Herman (1985) that it is *an exaggeration to claim that* [child sexual assault and] *incest inevitably leads to lasting emotional distress* (p.88). It is important to note that, as Herman comments, data on long-term effects of father-daughter incest are derived entirely from clinical reports, i.e. studies of women who identified themselves as patients in need of mental health services. She refers to Tsai's (1979) survey which indicated that at least some women with a history of child sexual assault perceive themselves as relatively well-adjusted in adult life, and that this correlated well with clinical assessments. These women acknowledged the trauma of child sexual assault, but believed they had escaped long-term distress by receiving helpful intervention from other people, such as family members and teachers.

I hold the view that child sexual assault does not necessarily lead to long-lasting 'intrapsychic damage', e.g. 'shattered ego'. The way I understand what has happened to the women I see in therapy is that they suffer difficulties in their adult life in response to repeating oppressive patterns of interaction in their family and other significant contexts. My perspective is interactional and

contextual, rather than intrapsychic and psychodynamic.

The more traditional intrapsychic perspectives view the client as having some kind of pathology which the therapist, as an expert on pathology, will fix through 'diagnosis' and 'treatment'. The implication of this way of thinking is that somehow the damaged personality of the client will be understood and repaired through the expertise of the therapist's interventions. (For further discussion about the implications of various ways of seeing the therapy process, including this way, see Epston & White 1989).

In contrast to this, a contextual, interactional perspective does not see the development of difficulties as taking place inside the person and as being pervasive to their personality. Instead, attention is paid to the various interactional contexts within which a person's difficulties may emerge.

A contextual way of viewing how difficulties may develop in the life of a woman who was sexually abused in childhood

- The experience of being sexually abused will initially lead to the young child having an array of confusing and overwhelming feelings, which strongly affect her perception of herself, e.g. she may begin to see herself as bad and dirty and believe she is to blame for the abuse. This is often encouraged by the perpetrator of the abuse, who may work very hard to ensure that the secret about the abuse is kept.

  Based on these experiences, the feelings and beliefs she begins to develop about them, the child begins to develop ways of dealing with her life, e.g. secrecy, and blaming herself when things go wrong, which serve to reinforce her feelings and beliefs about herself.

- Following the child's experience of abuse and the establishment of patterns of behaviour and thinking like secrecy and self-blame, the child responds to family members and others in ways which lead them to consider her 'naughty' or 'disturbed', e.g. she may act out sexually, be aggressive, or have mood swings. They will respond to her in the ways they usually do when they perceive her as being naughty or disturbed - e.g. punishment, or seeking professional help. The perpetrator of the abuse may also be continuing the abuse. All of these interactions serve to reinforce (a) the

patterns of behaviour around secrecy, and (b) the beliefs the child is developing about herself - e.g. 'I'm no good'. The family context may become a life-support system for these interactions and beliefs, which continue to have a negative effect on her view of herself and on her experience of relationships.

- Disclosure about the abuse may exacerbate the beliefs and behaviour, if the child is not believed. Alternatively, if the child is believed and supported, there may be a significant interruption of the kinds of interactions which secrecy encourages, e.g. more openness may be possible between the child and her mother and siblings. New interactional patterns, challenging secrecy, and self-blame, and the breaking of more family silences, become possible.

- If disclosure does not occur, or if the child is not believed and she continues to be influenced by secrecy and self-blame, her experiences as an adult woman of interactions in other significant relationships may further promote the survival of habitual responses and beliefs, e.g. she may blame herself or see herself as damaged if there are sexual problems in her relationship with her partner. She may seek professional help for herself and receive a diagnosis which serves to confirm her view of herself as a damaged person.

Details about the implications of this perspective for therapy will be discussed later in this chapter.

These ideas about the process of the development of difficulties for women who have been sexually assaulted as children are similar to those described by Durrant (1987). He talks about the experience of sexual abuse as one in which the child will have had no control over events when the abuse occurred. This experience of 'out-of-controlness' may be exacerbated by events that follow the abuse, e.g. the disbelief of other people. Durrant describes how the child may become caught up in a cycle of out-of-control behaviour and emotion, and how the distress may affect all aspects of her experience of herself. This process may continue into adult life.

I believe it is important to include, in this description about the child's family context, an acknowledgement of who it was that had control, i.e. who had the power to define the child's experience, and how was this achieved? I

am interested in the notion of including acknowledgement of the responsibility of the perpetrator of the abuse in an account of the development of the woman's difficulties and beliefs about herself. Clearly, there are often other significant relationships which play an important part in shaping a woman's view of herself. I am paying particular attention here to the woman's experience of the relationship with the man who abused her, as I believe this has been neglected in the literature.

Oppressive stories authored by perpetrators of child sexual abuse which influence the stories women who were abused tell about themselves[4]

These ideas are drawn from conversations with women about their experiences in their relationships with men who sexually abused them.

- It is usually the case that the perpetrator of the abuse has overtly or covertly conveyed to the victim the message that she was to blame for being abused, e.g. 'you led me on', 'you shouldn't dress like that - you were asking for it', 'this is all you are good for'. The perpetrator generally denies responsibility for the abuse, for its impact on the child's life and for the consequences to the family. This idea is strongly reinforced for the victim by messages she receives from the surrounding social context, e.g. 'only bad girls get raped', 'children are seductive', 'women who get raped must have asked for trouble', and so on. These interactions with the perpetrator will establish the conditions for the development and survival of habits such as self-blame and self-hate. These ways of thinking may permeate the woman's stories about herself.
- The perpetrator will often actively promote secrecy by enforcing it with the child or young woman so that she is divided from other family members. As a child, the woman often had no opportunity to check out her own reality because of the rule of secrecy. This contributes to her sense of isolation and confusion, which are devastating side-effects of secrecy. The perpetrator has the power to create a reality for the abuse, perhaps saying things like, 'all fathers do this', or, 'this is for your own good', or, 'you really like this', or, 'this is our special secret', to justify his actions. All of this may contribute to

the development of self-doubt in the woman's life, as the perpetrator's account of events has had precedence over her own. She may also become vulnerable to erasing her own feelings in response to this.

- The child's interactions with the perpetrator may have encouraged in her feelings of enormous responsibility for others. He may have directly suggested to her things like, 'I'll be sent away if you tell', or, 'your mother will have a breakdown if you tell her', or, 'you're the only one who understands me', or, 'I'll go and do this to your little sister if you refuse'. These kinds of ideas might be less directly implied. The effect of this is that the woman has received intensive instruction in putting others' needs first and her own last, and this may become an habitual pattern in her story about relationships.

- The various ways in which the perpetrator exerted control over the child - either subtly or directly, e.g. intimidation, violence - in order to continue to have access to her to meet his needs, may promote the development of habitual responses of fear and panic in intimate relationships when she becomes an adult. Fears may figure prominently in stories she tells about herself (Laing & Kamsler 1988).

  Therefore, the woman who was sexually abused in childhood may be seen as not simply under the influence of the past, as Durrant (1987) suggests, but also under the influence of a number of prescriptions for how to feel, be, and think, which were actively promoted by the perpetrator in his interactions with her.

It is clear that there is a high degree of fit between many of these prescriptions and the predominant role definitions for women which are expressed in patriarchal ideology. Indeed, Waldby (1987) comments:

> *The kernel of the feminist understanding of incest is formed by the assertion that father-daughter sexual abuse is a particularly intense variant of 'normal' male-female relations in a patriarchal society.* (p.17)

She quotes O'Donnell & Craney's (1982) idea that the incest victim *bears the quintessence of female oppression* - she is introduced to *the role of the powerless, dutiful, submissive wife* (as mentioned in Waldby 1987, pp.17 &

19). The child's interactions with the perpetrator can be described as 'intensive training' for her in fitting with the stereotypical submissive female role. The groundwork has been thoroughly prepared for the woman to respond in strongly gendered ways in other significant relationships. She may begin habitually to apply the perpetrator's prescriptions to herself in numerous situations, e.g. putting her own needs aside and developing a 'being for others' lifestyle in her relationships, being passive, being obedient. Thus, the effect of these interactions in childhood may be that she conforms even more strongly to gender prescriptions for women. This perspective about women experiencing the disempowering effects of a relationship which echoes the oppressive arrangements between men and women in society is missing in most of the writings about therapy in the area of child sexual assault.

To sum up, I believe that the significance of the whole context of a woman's experience has been insufficiently explored in the literature which discusses ways of doing therapy with women who were sexually assaulted in childhood. The woman's life is viewed entirely through an intrapsychic lens in the majority of articles about the long-term effects of child sexual assault. A consideration of the significance of her experience of interactions with the perpetrator in the development of problems, together with the influence of ideas from the broader social context, is entirely left out in many articles and books. This omission frequently leads the therapist to consider the difficulties presented by the woman in therapy as being related to her individual pathology or to dysfunctional family relationships. I believe it is crucial for a therapist to operate from a framework which allows issues from both the woman's familial and social context to be accessed and addressed in therapy.

Framework for Therapy

Theory about development of problems

The framework for therapy that I have started from in working with women is the approach being developed by Michael White, which was initially based on Bateson's cybernetic notions of restraints and information. The pivotal ideas about restraints in cybernetic theory suggest some useful ways to consider the situation of women who were sexually abused as children. The

approach understands the development and consolidation of problems in terms of the idea that events take their course because they are restrained from taking alternative courses (White 1986, p.169).

A therapist operating from this perspective constructs the situation of people presenting problems as being a consequence of the operation of retraining beliefs and assumptions about themselves and their world. These beliefs and assumptions do not allow them to have access to alternative solutions to their difficulties. This is because information which does not fit with the restraints is screened out and not perceived. This way of constructing things allows the therapist to view the development of problems as occurring in the context of habitual thoughts and feelings and repeating interactional patterns which prevent the person from having certain information about their own resources which may be useful in solving the problems they are struggling with. For example, a woman who was sexually abused in childhood may habitually blame herself for the abuse and be unable to 'notice' the perpetrator's contributions to the situation. She can be described as being blind to other information which might assist her in responding differently to the past and present relationships. Clients are seen as being out of contact with information about their own resources which might assist them in handling problems as a result of the operation of restraints. This concept allows us to understand how it is that clients repeatedly apply the same attempted solutions despite the fact that they may in fact perpetuate the problem.

I have already described examples of restraining ideas and patterns in my discussion about the impact of the woman's childhood interactions with the perpetrator, e.g. secrecy.

Here is an example of the way restraints contribute to a woman habitually applying solutions which perpetuate the problem:

> *A child is sexually abused by her father who tells her, 'All fathers do this - what are you getting upset about?' However, she is upset and anxious and eventually tells a teacher who does not believe her and tells her not to worry about it. She decides not to tell anyone else. The child believes it is she who has the problem and blames herself for the abuse, and this idea restrains her from making a different response. As an adult, whenever she thinks about what happened to her, she doesn't tell anyone and continues to think it was her fault. Secrecy and self-blame become strong influences in her life*

and relationships. Her distress increases - the more this happens, the more she blames herself, and it becomes even harder to think about telling someone.

Recently I have employed White's idea of a text analogy for therapy (White & Epston 1989) which gives another description of the approach. Using this analogy, the development of problems is seen as taking place in the language and conversation of those most concerned about them. People who present to therapists with problems are seen as being intensely focussed on 'problem-saturated' descriptions about their situation, and as being out of touch with their capacity to be successful in the face of their difficulties. Problems are seen as a story or idea with a history and a future - as being directional, as having a lifestyle support system, and as being progressive, i.e. they are located in a sequence of events across time. People presenting for therapy are said to have co-evolved with others significant to them around certain realities, and the 'dominant story' they tell about themselves (i.e. the problem-saturated description) has been reinforced in many ways, leaving no space for them to perform another story - the story about unique outcomes, or occasions where the person was in fact able to have some impact over the problem. Events are interpreted through the lens of this dominant story, which shapes the way persons attribute meaning to their experiences.

Here is an example of how the person's 'dominant story' restrains them from having access to their own resources:

A woman called Alice was referred to me - she was having persistent nightmares, was very concerned that she found it hard to sustain relationships with men, and saw herself as being irrational and disturbed. She said she had been sexually abused over six years by her grandfather when she was a child, and had been physically and emotionally abused by her mother, father, and stepmother. She believed that she was a 'mess' and, although she thought this was to do with her past experiences, she had accepted family members' views of her as being emotionally disturbed. In her own words, 'I'm fucked'. She seemed to have the view that she was a damaged person who was possibly beyond repair. This story pervaded her descriptions of herself so strongly that she was initially unable to identify any information about herself which deviated from the view that she was a

> *'mess'. She persistently blamed herself for her situation and put herself down - in her own words, 'I had a total belief that I was a difficult and unlovable person'. This story was reinforced in her interactions with all family members who responded to her distress by rejection or withdrawal, and this seemed to lead to her experiencing increased distress which would lead to them seeing her as more disturbed, and so on. This story was also perpetuated in her experience of interactions in other significant relationships throughout her life.*

I will refer to Alice's story in more detail later in this chapter.

In addition to the concepts I have described, I am interested in the idea that the stories people have developed about themselves are located in the context of certain ideologies which are cultural and socio-political stories. White has drawn on the work of Foucault in elaborating this idea, and suggests that therapy can be a context for challenging the way the ideologies, or dominant knowledges, operate. In relation to incest, I believe the dominant knowledges which influence women in constructing their personal stories are patriarchal ideology and the whole area of psychiatric diagnosis and classification. These are the linguistic and epistemological contexts in which incest has traditionally been located.

Therapy

What follows from these ideas about problem-development is that a context for change can be established through the therapist working to promote double description extensively in therapy. This means that the therapist works with clients to develop many new descriptions of events in order to generate 'news of difference which makes a difference' (White 1986), i.e. to challenge or loosen restraints, including the restraining beliefs from patriarchy and psychiatry. Clients need to be able to draw distinctions, to perceive a contrast between their own description and a new description, for them to receive news of difference or new information. This process triggers new responses which make it possible for them to see new solutions. The new description is co-evolved with the therapist participating actively in introducing new descriptions, often in the form of questions, and building on these new

descriptions in response to the client's responses.

As Munro (1989) says:

> *Double description challenges restraints, thus triggering new solutions. For example, the second description and the new perceptions this offers, enables clients to experience a view of the problem* [and of themselves] *which is not bound by the restraints under which their first description operated.* (p.185)

The therapist assists the client to develop the new description in a variety of ways which White elaborates in his articles and teaching, e.g. externalizing problems, relative influence questions, collapsing time, raising dilemmas, and responding to responses (White 1986).

These foundation ideas about the approach have been extended in a new direction recently in White's re-description of his work, which he believes fits best with a text analogy for therapy. Clients are seen as being under the influence of a dominant story about themselves, their relationships, and the problem itself. Their descriptions of themselves are understood to be dictated by the dominant story, and the many alternative stories which they could potentially express about their competence and resourcefulness are not given space to be performed. It seems to me that restraints are the beliefs and patterns of interaction that support the dominant story.

The goal of therapy is to invite clients to access aspects of their experience of themselves which have been edited out of the dominant story. The critical steps in assisting clients to locate alternative stories about themselves will be described, together with examples from my work with women who were sexually assaulted in childhood.

Externalizing the problem

Tomm (1989) has described the therapeutic activity of externalizing the problem, which is central to the practice of this approach, as *a linguistic separation of the distinction of the problem from the personal identity of the* [person]. He believes that this process *opens 'conceptual space' for* [people] *to take more effective initiatives to escape the influence of the problem in their lives* (p.54). The effect of externalizing the problem is to begin to undo some of the negative effects of diagnosis and labelling. I believe this is of profound

importance in the area of child sexual abuse where, as I have described, there has been a tradition of applying pathologising, static labels to women. The labelling process encourages conversation in terms of diagnosis. This supports the view that the problem is the woman herself, and reinforces self-blame and guilt. Externalizing the problem is the first step in inviting the woman to separate herself from the effects of labelling, and this leads to the possibility of her noticing alternative stories about herself as a person who at some times has not let the problem entirely overtake her life.

As White (1988/89) says:

> *From this new perspective, persons* [are] *able to locate 'facts' about their lives and relationships that could not even be dimly perceived in the problem-saturated account … facts that provided the nuclei for the generation of new stories.*

The conversations I had in therapy with a woman called Beth contained some examples of externalizing the problem. Beth told me in our early meetings about how she had disclosed to family members that her father had sexually abused her over a number of years when she was a child. She talked extensively about her guilt over the abuse and her fears about coping with life. These feelings had at times in the past pushed her into attempting suicide and believing she was having a 'breakdown'. I externalized secrecy initially, and invited Beth to map its influence on her life and relationships. Fear, guilt and super-responsibility for others appeared to be the major effects, and I externalized each of these, e.g. asking her about what impact fear had had in her life and on her relationships.

Locating the dominant story in the context of interactions, and in the wider social context

Once the problem has been externalized, the dominant pathologising story which the woman tells about herself is externalized. I believe it is helpful to assist her to locate where this story came from and to develop some ideas about how it became so influential over time. Questions can be introduced, such as: 'How was secrecy encouraged by other people in your life?', 'How was secrecy enforced?', 'What training did you get at favouring others over yourself?' These kinds of questions allow the woman to begin to gain access to

the contributions of others, through their interactions with her, to the development of the difficulties she faces. I believe that eliciting a full picture of this is very important, as it facilitates the naming of the oppressive practices which have allowed the effects of child sexual assault to survive. This further assists the woman to separate from the pathologising picture she has of herself, because she becomes more aware of the whole context of her own experiences, including the context of her interaction with the man who abused her, e.g. when I asked Beth what training she thought she had received in super-responsibility, she talked with me about the ways in which her father had intimidated her so that she would comply with his demands on her (sexual and otherwise); her life as a child became focussed on ensuring that she looked after his needs as a priority.

Questions may potentially be introduced which can assist women to locate their experience of the problem in terms of the limiting effects on them of bigger, socio-political stories or ideologies. For example, I asked Beth whether she thought that there are ideas in society which might support habits of super-responsibility for women. She readily identified many examples, and together we explored the consequences of this for her as a person. White's (1986) paper on anorexia suggests some useful directions for questions which give women an opportunity to assess the impact on them personally of society's prescriptions for women.

Relative influence questions

This approach contains some very helpful ideas about how to invite clients to re-tell their story in such a way that they have access to their experience of their own resourcefulness in the face of the problem (White 1988, 1988/89). Two categories of questions can be introduced - one to map out the details and effects of the dominant story, e.g. 'What influence have fears had on your life? on your relationships with other people?', and one to begin to map out the 'unique outcomes', or the occasions where the woman experienced some influence in her own life despite the power of the dominant story. For example, any disclosure of sexual abuse is a direct attack on secrecy, and is a unique outcome. A woman may be asked whether she had ever told anyone she was sexually abused, and this could be followed by an exploration, e.g. 'How

was it that you defied the secrecy when you disclosed about your father abusing you?' It is crucial that a thorough exploration of the first category of questions, about the dominant story, is entered into before unique outcome questions are introduced.

It is not my intention to cover the many and varied ways a client can be invited to identify unique outcomes. However, when the therapist asks unique outcome questions like, 'Was there an occasion when you could have been stopped in your tracks by fear but you withstood it instead?', space is opened for the client to begin to author an alternative story about herself.

Questions to invite an elaboration of the alternative story

The client is invited to 'perform meaning' around the unique outcomes which are identified. The kinds of questions asked ensure that the woman is able to attribute personal meanings to events, and to experience the impact of the new emerging story. This is a prerequisite for the survival of the new story. The client is invited to locate a full account of the unique outcomes in a new, alternative story about her lived experience. The goal of this is to ensure that the person experiences the full significance of the unique outcomes. This process of inviting people to go back to their own experience and bring forth alternative stories about themselves leads to them having a different experience of themselves. The role of the therapist throughout therapy could best be described as co-author of these emerging alternative stories.

The following questions came from my conversations with Beth:

- *How was it that you defied secrecy and your father's training in putting others first when you disclosed about the abuse?*

When Beth identified some other occasions when she had put herself first, I enquired about them in detail:

- *How were you able to do this?*
- *How did you give yourself priority?*
- *How do you account for the fact that you felt strong enough to withstand the habit of putting others first?*
- *How did you withstand your father's training?*

- *What did you experience?*
- *What difference has this made to your experience of yourself?*
- *What does this tell you about yourself that you didn't realise before?*
- *How could you bring your friends up-to-date with this development?*

There are countless ways a therapist can participate with the client to develop and extend the alternative story. White's papers outline the kinds of questions which appear most likely to further the co-authoring of alternative stories.

The application in therapy of ideas such as externalizing problems and unique outcome questions allows the therapist to assist the woman to locate her experience in the context of family interactions, including the relationship with the perpetrator. It also allows her to locate her experience in terms of the broader socio-political context. In the process of therapy, the woman has the opportunity, in conversation with the therapist, to discover information about herself and her resources. This leads to her responding in ways which pave the way for change. The emphasis here is on the idea of the client as expert, with the therapist's role being to ask questions which generate unique outcomes and new stories. This is in contrast to more traditional ways of doing therapy where the therapist is seen as the expert who has the knowledge to diagnose and fix the client's problems.

The approach outlined here taps knowledges a woman has about herself and her strengths, which have been buried as a result of the operation of the dominant story. When the woman is invited to separate herself from the dominant story, and new information is generated, the dominant knowledges which the woman drawn upon to define herself are thereby challenged, and new responses and solutions become available to her.

The Story of Alice: An illustration of the therapy process[5]

Alice is a woman I have seen in therapy over the last two years. She has agreed to allow me to share this story, which includes her comments on her experience as a client, which she decided to write down as a way of reviewing it for

herself.

Alice was referred to me by a therapist at Dympna House, where she had participated in a self-help group for incest survivors. When she contacted me to make an appointment, she said she wanted help in two areas:

- Handling her nightmares. Over the last two years she had been experiencing long periods of disturbed sleep as a result of terrifying dreams. The nightmares would persist over months, occasionally disappear for short periods, then suddenly recur for months on end.
- When she was involved in relationships with men she would feel comfortable for a short time, but end up feeling revulsed in sexual situations. She would often finish relationships based on this. She saw this as being related to her experiences of sexual abuse.

Alice said that she had sought therapy earlier in her life to deal with her distress about her family and with her memories about being sexually abused by her grandfather. Individual and group therapy had helped to some degree, and she said that she had felt that she was not so alone on learning that the experience of child sexual abuse was a common one among women. However, despite her previous attempts to get help, she was still feeling very distressed and confused about her life.

Sessions 1-3

Alice began by presenting to me her concerns about her nightmares and relationships. She also talked about her experiences of being sexually abused by her grandfather from age four to age eleven. Her parents had separated in the UK when she was three years old, and her father was given custody of her as her mother was seen as being ‘emotionally unstable’. She and her father came to Australia, where her father met and married his second wife. It was this woman’s father who sexually abused her. She described how she had disclosed about the sexual abuse to her stepmother during adolescence, but was not believed until her stepsister disclosed that the same thing was happening to her. No action was ever taken outside the family over this - the stepmother confronted her father, but did not support Alice. Alice described the ongoing conflict which she had with her stepmother and father, which led to her being

asked to leave home at seventeen. In Alice's view, every interaction with members of her family - including the infrequent contact with her mother - was an experience of rejection and invalidation.

The focus of the first three sessions was not on nightmares, sexual abuse, or current relationships with men. Alice talked with me in detail about her worry about therapy and her distrust of therapists. I took the sessions slowly, believing that her worry about trusting me was an important restraint in the relationship with me. I asked her to simply consider the risks of getting involved in therapy and to begin to keep track of the occurrence of the nightmares in a diary.

Alice noticed during the first three sessions that she was experiencing more sadness, and began to talk about how difficult and uncomfortable it was for her to show her feelings to other people. This she saw as a big risk in being involved in therapy where she might get more in touch with herself and her needs and feelings. She voiced her fear that 'there is so much there' that she wasn't sure that she or the therapist would cope. I externalized her habit of hiding feelings, and we explored the effect of this on her life. I discovered that she had received training from family members in not showing feelings as this meant she was 'irrational' and 'bad' like her mother was. Her mother was portrayed to her as incompetent and volatile. She said that she had learnt by her experiences of rejection and the disbelief of other family members when she was upset that no-one could handle her feelings, so she just coped on her own with them. We talked about how she had learnt not to be herself, developing the habit of being someone else's kind of person rather than being her own person (another externalization) in response to family members' requests to not be so emotional. She talked about her isolation, and cried about how sad she felt that no-one in her family had supported her or believed her distress about the sexual abuse.

I began to attempt to get a picture of the unique outcomes by asking Alice whether there had ever been occasions where she had rebelled against these habits and prescriptions and been herself in relationships. She identified occasions where she had taken risks and asked for support from friends. I asked her to supply some details about how she had been able to do this, given the intensive training she had had in not being herself and hiding herself. I also talked with her about how it was she was able to challenge the training, in

allowing herself to feel so much during our meetings.

During the first three sessions, Alice's nightmares disappeared - the more she acknowledged her sadness and fear, the less she experienced it at night. She also took the step of contacting the state welfare department and giving them information about her grandfather, although she did not lay charges. I responded to this information with questions to extend the account about unique outcomes, e.g. how had she had the courage to be herself in these situations? It was in session 3 that Alice first talked with me about her habits of peeling skin off her face and arms, and of bingeing and vomiting. She had never told anyone about these habits before. I externalized them, using the word 'habits' to describe them. I believe this was another breakthrough in Alice challenging the effects of her training in not being herself. Alice said quite strongly that she did not wish to focus on these habits as they were not really that much of a problem at present. This continued until later in therapy.

Sessions 4-6

Alice continued to report having nightmare-free nights and to make changes in being more open about her vulnerability to friends and some family members. She made further disclosures to me about being violently physically abused by both her mother and stepmother, and we talked about how this had fed her developing habit of not being herself, of self-invalidation and self-depreciation (further externalizations). It became clear to me from her descriptions about feeling ripped off by others in her family that the sexual abuse was only one way in which Alice had experienced invalidation of herself as a person.

An important focus of this part of the therapy was on seizing on any information Alice gave me about unique outcomes, e.g. times she was open to other people about her feelings. I would elicit the details around these events to allow for a performance of meaning about her escape from her habits of self-invalidation. I was also able to develop with Alice an account of her survival strategies when she was growing up, so that I might understand how she had stopped herself from being completely overtaken by self-invalidation. She recounted her story of survival as a child by describing how she wrote stories and poetry which expressed her feelings. This was a special and precious thing

she did when she locked herself in her room, to have breathing space from family conflicts. I asked her whether there were any survival strategies which she had continued to use in the present, and she identified that she was still valuing her own self-expression through singing and occasionally through writing songs. She was able to tell me that she was removing herself from some situations where she was feeling 'done over'. I described this as trusting herself, and as going against her habit of self-invalidation. Once again, I explored the details of these occasions of self-validation to encourage a performance of meaning around them.

Alice made further small but significant changes in the direction of valuing herself and being more true to herself. However, she frequently trivialised her achievements. She said she kept seeing herself as 'fucked', and this made it hard for her to notice changes. When I talked with her about whether she thought she was ready to take any further steps in the new direction, she began to talk about her fears in relation to having to start a new life as a different sort of person if she went further with the changes. At this point, I restrained further changes. I invited her to keep track of any examples of occasions where she was being true to herself or valuing herself.

Sessions 7-10

When I enquired about the extent to which self-appreciation was evident in her life versus the extent of self-depreciation, Alice began to describe more examples of times when she had valued something about herself. I gathered a lot of details about these examples, and she then spontaneously recalled further occasions of self-appreciation. As this progressed, Alice noticed that she had started to break with her habit of being for others in friendships and of putting others' needs before her own:

> *The most important strategy for me was to acknowledge and leave behind contexts that continued to arouse and create pain.*
>
> *Once I was able to do this, I was able to construct new ways of interacting with people, in more positive and self-gratifying relationships. I didn't insist on maintaining relationships out of guilt or self-destruction, and saw the benefits of trusting people and establishing supportive*

relationships. (1988)

At this point, she once again started to talk about her habit of bingeing and vomiting, saying that it was happening more often. I got some details about this by asking her about the effect bulimia had had on her life, and she was able to talk with me about some periods of her life where she had escaped bulimia, as well as about how she had achieved this (tracking unique outcomes). During this phase of therapy, Alice put me in the picture about further ways she had been in training to see herself as 'fucked' (e.g. significant upsetting interactions with her mother), and the ways in which she thought she had been affected by this training, e.g. hiding herself, fears of rejection if she was more herself, and seeing herself as being responsible for everything that has gone wrong in her life. I talked with her about the habit of bulimia being a way she could be less 'herself', and this was an idea she could connect with. I suggested she keep track of times where she refused bulimia's invitations (tracking unique outcomes).

Sessions 11-14

Alice began to have some victories over bulimia and, for the first time, to allocate more responsibility to family members for her distress. I explored these developments in detail, describing them as achievements in self-appreciation. I talked with her about her ideas about how bulimia had originally become so influential in her life. She identified the origin of many secret habits in her life, including bulimia, in response to the extreme reactions of her parents to her developing sexuality. I also asked her about things like, in what ways she thought she had subjected herself to fitting with ideal images for women in terms of shape. I enquired about whether she thought these images might further have encouraged her to be less than herself, and she agreed this may have been the case. We talked in detail about the occasions where she had beaten bulimia and, as sessions went on, she had more victories over it. In response to this, I asked her questions like: 'How do you think it was possible for you to allow yourself to be more fully yourself on that occasion?', 'How were you able to break away from subjecting yourself to society's prescriptions for thinness for women, and to appreciate yourself in this way?'

In some of my questions I was inviting her to identify the influence on her personally of the broader social context of patriarchy which supports the idea of women being less than themselves, or invalidating themselves. I was also inviting her to consider ways she had been for herself and had withstood these prescriptions.

Alice experienced a period of anxiety in response to the changes she was making. She talked about being worried about losing her 'old self' - who would she become? She also described her habit of picking at herself for the first time in more detail. We tracked the story about how this habit had become stronger recently. I was also able to locate some unique outcomes, or occasions where she had not given into the habit. However, Alice said she was unsure about whether she wanted to talk further about this habit. I asked her to consider the consequences of talking further about it in therapy.

Alice then began to recall some frightening situations which happened to her as a child at bedtime, and together we recognised how the picking habit had become an ally to fear. It had become a way to hypnotise herself and stop fear, and another way to 'lose herself'. I suggested that she schedule half an hour each night for this habit so that she might get more information about how it helped her with her fears. To use Alice's own words:

> *Upfront acknowledgement, and giving myself permission to include these* [habits] *in moderation, allowed me to change my perspective on these behaviours and slowly take control of them.*

Alice was noticing, at this stage, that she was no longer letting her distress in any one area of her life overwhelm all the others, and that she experienced a sense of feeling more in control.

Sessions 14-20

It was clear that Alice was experiencing more control over her self-destructive habits. She recognised readily how she was able to stop herself from being taken over by them - our conversation contained more spontaneous examples from her about this, and less examples about being overwhelmed by the habits. She discovered many new strategies for handling her fears at night, e.g. by listening to music to help her relax.

The problem-saturated description was taking up less space in therapy, and Alice was constructing a new story for herself. When I explored how all this had been achieved, Alice said:

> *I've changed my ideology about myself. At first I thought, 'I'm fucked'. Then I moved on to thinking, 'They're fucked', about my family. Now I believe that I'm okay - I have my problems in life, but I am okay and I am healing myself.*

She also said that she felt less anxious and worried about herself generally, and this meant that she had more space to deal with the self-destructive habits.

To encourage a performance of meaning around these numerous changes, I asked her about what difference this new view of herself was making to the way she treated herself day-to-day, what difference this made to her relationships with family and with friends, and about what new possibilities these changes might open up for her.

I predicted 'hiccups' with the habits, and we discussed how she might deal with them, e.g. scheduling in time for the picking habit.

Alice has maintained these changes, with bulimia and picking at herself almost disappearing from her life. She has formed new relationships in which she experiences caring and acknowledgement. She says she now believes she is competent and is actively achieving changes in her own life. She describes the experience of seeing herself in a context when problems occur, i.e. she no longer labels herself as a problem when things go wrong. She reports feeling good and valuing herself in the presence of people who have been problematic for her in the past. She has had some hiccups, but does not feel overwhelmed when they occur. She has made many steps, which she has drawn my attention to, in being more fully herself, in valuing herself, and in being less a person for others and more for herself.

I have stopped having regular sessions with Alice and have invited her to contact me if she wants to review things with me. I recently saw her when she experienced a hiccup in relation to the break-up of a relationship. She continues to experience a sense of control over her own life, e.g. recently she has come up with the idea of using her dreams as resources for herself.

> *I'm not perfect, I'm still self-critical and constantly striving for self-*

improvement - but I'm okay and I like myself and, despite my normal emotional ups and downs, I understand myself and my reactions and I now feel in control and able to move on past the pain of my past. (August 1988)

Conclusion

In conclusion, I believe that there are many unhelpful, limiting and potentially oppressive ideas being applied in the service of therapy with women who were sexually abused as children. My preference has been for a framework which acknowledges and accesses the influence of familial and relationship contexts (including the context of the woman's relationship with the man who abused her), as well as the influence of restraining ideas from patriarchal ideology, in the process of the development of problems in the woman's life. Therapy may be seen as an opportunity to address restraints or dominant stories, through the therapist assisting the woman to generate double descriptions or alternative stories; this allows the woman a chance to re-tell her story about herself. It has been my experience, in approaching therapy like this, that many women have responded by strongly challenging the dominant stories in creative ways, finding solutions which have been empowering for them.

Acknowledgements

I wish to thank Lesley Laing and Catherine Munro, who have each made particular and special contributions in helping me develop ideas which have been critical to the writing of this chapter. I am very grateful to both of them for their assistance with various drafts of the chapter, and for their invaluable support. I am grateful to Bronwyn Cintio for her assistance in the early stages of writing the chapter. Finally, I wish to thank Michael White for his encouraging comments about the chapter, and Steven Kamsler and Melanie Kamsler for their loving support.

Notes

1. First published 1990 in Durrant, M. & White, C. (eds), *Ideas for Therapy With Sexual Abuse.* Adelaide: Dulwich Centre Publications. Republished here with permission.

2. Amanda lives and works in Sydney, Australia, and has been exploring narrative ideas and practices for over ten years in the course of her work as a therapist. During this time she has been refreshed and inspired by the experience of working alongside the people who meet with her as they discover untold possibilities in their personal and professional lives. She has also enjoyed the great conversations that have been unfolding through having the opportunity to offer presentations and workshops in Australia, New Zealand, Canada and USA. Amanda can be reached by phone or fax at (61-2) 9958 5418, and her email address is kamsler@ozemail.com.au
3. These are the definitions adopted by Dympna House.
4. I wish to acknowledge the original work of Lesley Laing, who was the instigator for ideas expressed in this section of the chapter.
5. I would like to acknowledge the valuable contribution of Catherine Munro, with whom I consulted at various stages of this process.

References

Blake-White, J. & Kline, C.M. 1985: 'Treating the dissociative process in adult victims of childhood incest.' *Social Casework*, September, pp.394-402.

Calvert, G. 1984: 'Letter to the Editor.' *Australian Journal of Family Therapy*, 5:1.

Deighton, J. & McPeek, P. 1985: 'Group treatment: Adult victims of child sexual abuse.' *Social Casework*, September, pp.403-410.

Durrant, M. 1987: 'Therapy with young people who have been the victims of sexual assault.' *Family Therapy Case Studies*, 2(1):57-63.

Ellenson, G. 1985: 'Detecting a history of incest: A predictive syndrome.' *Social Casework*, November, pp.525-532.

Faria, G. & Belohlavek, N. 1984: 'Treating female adult survivors of childhood incest.' *Social Casework*, October, pp.465-471.

Furniss, T. 1983: 'Family process in the treatment of intra-familial child sexual abuse.' *Journal of Family Therapy*, 5:263-278.

Gutheil, T. & Avery, N. 1977: 'Multiple overt incest as family defence against loss.' *Family Process*, pp.105-116.

Herman, J. 1985: 'Father-daughter incest.' In Burgess, A. (ed), *Rape & Sexual Assault - A Research Handbook.*

Justice, B. & Justice, R. 1979: *The Broken Taboo: Sex in the Family*. New York: Human Sciences Press.

Laing, L. & Kamsler, A. 1988: Training workshops for therapists working with women who were sexually abused in childhood. Sydney, Australia.

Lustig, N. et al. 1966: 'Incest: A family group survival pattern.' *Archives of General Psychiatry,* 14:31-40.

Machotka, P. et al. 1967: 'Incest as a family affair.' *Family Process,* 6:98-116.

McCarthy, I.D. & Byrne, N.O. 1988: 'Mis-taken love: Conversations on the problem of incest in an Irish context.' *Family Process,* 27(2):181-199.

Munro, C. 1989: 'White and the cybernetic therapies: News of difference.' *Australian & New Zealand Journal of Family Therapy,* 8(4):183-192.

O'Donnell, C. & Craney, J. 1982: 'Incest and the reproduction of the patriarchal family.' In O'Donnell, C. & Craney, J. (eds), *Family Violence in Australia.* Cheshire: Longman.

Shapiro, S. 1987: 'Self-mutilation and self-blame in incest victims.' *American Journal of Psychotherapy,* 41(1):46-54.

Tomm, K. 1989: 'Externalizing the problem and internalizing personal agency.' *Journal of Strategic & Systemic Therapies,* 8:1.

Tsai, M. et al. 1979: 'Childhood molestations: Psychological functioning in adult women.' *Journal of Abnormal Psychology,* 88:407-417.

Waldby, C. 1987: 'Theoretical perspectives on incest: A survey of the literature in breaking the silence.' *Breaking the Silence: A report based upon the findings of the Women Against Incest Phone-in Survey (Sydney 1984).* Haberfield, Australia: Dympna House.

Ward, E. 1984: *Father-Daughter Rape.* London: The Women's Press.

White, M. 1986: 'Negative explanation, restraint & double description: A template for family therapy.' *Family Process,* 25(2):169-184.

White, M. 1986: 'Anorexia nervosa: A cybernetic perspective.' In Elka-Harkaway, J. (ed), *Eating Disorders.* Maryland: Aspen Publishers.

White, M. 1988: 'The process of questioning: A therapy of literary merit?' *Dulwich Centre Newsletter,* Winter.

White, M. 1988-89: 'The externalizing of the problem.' *Dulwich Centre Newsletter,* Summer.

White, M. & Epston, D. 1989: *Literate Means to Therapeutic Ends.* Adelaide: Dulwich Centre Publications. (Also published as White, M. & Epston, D. 1990: *Narrative Means to Therapeutic Ends.* New York: Norton.)