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Adults traumatized by child abuse: What survivors need from community-based mental health professionals

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Abstract

Aims: To understand, from the "insider" perspectives of adults abused as children, the aspects of community mental health interventions that are experienced as helpful and less helpful after discharge from inpatient trauma treatment.
Method: In-depth interviews were conducted with 30 child abuse survivors, six months after discharge from a specialized trauma treatment program.
Results: Participants reported difficulties managing intense feelings that surfaced after inpatient treatment, which became more problematic when they could not talk about them honestly with their community-based therapists. Therapists who were patient, understanding, and respectful of survivors' needs for a sense of control in working toward their own solutions were most helpful. Participants emphasized the need for accessible trauma-based treatment from clinicians.
Conclusions: Many communities in Canada, due to lack of resources, are not providing trauma-specific services. This study indicates that community-based therapists need to become more knowledgeable about trauma issues, to increase their ability to work collaboratively with adults abused as children in assessing their therapeutic needs, and to ensure that survivors have some control in the treatment process.
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Introduction

Many adults seeking mental health services report a history of child sexual and/or physical abuse (Courtois & Bloom, 2000). Studies have found that the percentage of individuals using mental health services reporting child sexual abuse ranges from 12–50% (Wurr & Partridge, 1996), with women reporting such abuse more often than men (Brown & Anderson, 1991; Goodman et al., 2001; Windle, Windle, Scheidt, & Miller, 1995). The proportion that

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reports child physical abuse ranges from 10–57% (Brown & Anderson, 1991; Goodman et al., 2001; Mueser et al., 2004; Nilsson, Bengtsson-Tops, & Persson, 2005; Rosenberg, Rosenberg, Wolford, Manganiello, Brunette, & Boynton, 2000; Windle et al., 1995).

Recent research indicates that adults with histories of childhood physical, sexual, and emotional abuse frequently present with symptoms of post-traumatic stress disorder (PTSD) and other psychiatric disorders that require specialized treatment. Borger, Cox, and Asmundson (2005) found that almost 76% of adults reporting child physical abuse and neglect had at least one psychiatric disorder in their lifetime and nearly 50% had three or more psychiatric disorders. Furthermore, studies of childhood trauma survivors have noted that problems in emotion regulation and interpersonal functioning are as common as PTSD symptoms, supporting the contention that the diagnosis of PTSD as defined in the DSM-IV does not capture the full extent of mental health problems commonly found in adults with histories of child abuse (van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). A study that examined the relationship between child abuse, lifetime diagnosis of PTSD, and complex PTSD (or DESNOS, disorder of extreme stress not otherwise specified) found that 72% of those who were diagnosed with PTSD also met the criteria for lifetime complex PTSD (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997).

It seems clear, then, that many of the clients seen by mental health professionals have histories of child abuse and neglect, and that they frequently present with a range of symptoms and behaviours associated with the traumatic effects of such maltreatment. It appears, however, that many of these individuals have difficulty seeking and receiving effective treatment. Palmer, Brown, Rae-Grant, and Loughlin (2001) reported that when adult child sexual abuse survivors in Ontario, Canada attempted to obtain treatment, many reported long wait periods, available therapy was not affordable, and helping professionals did not have specialized abuse training; furthermore, many felt ''judged'' by the therapist, or said that treatment duration was insufficient in length. Similarly, in a study of psychiatric outpatients, Switzer, Dew, Thompson, Goycoolea, Derricott, and Mullins (1999) found that clients with PTSD reported less satisfaction with services than those without PTSD. They proposed that dissatisfaction with the services may have been related to the failure by mental health professionals to recognize and treat the PTSD. In addition, previous unsatisfactory experiences with helping professionals can cause survivors to be suspicious of health care professionals generally (Monahan & Forgash, 2000), thereby negatively affecting future help-seeking behaviour.

Practice guidelines for the treatment of PTSD, based on well-controlled studies, have been developed (Foa, Keane & Friedman, 2000). Without doubt, these guidelines have advanced the ability of many practitioners to provide effective treatment for individuals suffering PTSD; however, the large majority of the studies on which the practice guidelines are based sampled for trauma experienced in adulthood only, and only two studies specifically studied adult survivors exposed to trauma in childhood (Spinazzola, Blaustein & van der Kolk, 2005). Moreover, the participants in these studies often excluded participants with comorbid disorders such as substance abuse, bipolar disorders or suicidal ideation (Spinazzola et al., 2005). Although the methodology and reporting of studies published since the development of the PTSD practice guidelines has improved somewhat, more research that uses less restrictive exclusion criteria and naturalistic clinical samples is needed to determine what approaches are effective for individuals with complex adaptations to traumatic childhood abuse (Spinazzola et al., 2005).

We believe that in addition to the findings of randomized clinical trials, effective practice requires that clinicians and researchers also attend to what clients are able to tell us about their experience of what works when they seek mental health treatment. The purpose of our

study was to understand, from an "insider's" perspective, what adults abused as children experienced as helpful and less helpful when they attempted to access treatment services in the community after discharge from a specialized inpatient trauma treatment program. The study also investigated what conditions, from their point of view, supported or interfered with their help-seeking behaviour. The findings presented here were gathered during a larger project that studied outcomes at several points following discharge from an inpatient trauma program at a small hospital in southwestern Ontario (Stalker, Palmer, Wright, & Gebotys, 2005). Clients participated in this program most often because their symptoms and distress were significantly interfering with their daily life functioning, and previous treatment (both inpatient and community-based) had not resolved the difficulties.

Inpatient trauma program

The trauma program referred to herein is a six-week inpatient program that serves adult survivors of trauma, most of whom have been physically, sexually, and/or emotionally abused as children. It is located in a semi-private hospital in a small city in southwestern Ontario, Canada. Modelled on an adaptation of Bloom's sanctuary model (Bloom, 1997), the creation of physical and emotional safety within relationships in the therapeutic setting that can be transferred to relationships in the community, is of primary importance. A multidisciplinary team including psychiatry, psychology, nursing, occupational therapy, social work, recreation therapy, creative arts therapies, horticulture therapy, and pastoral care delivers the program, primarily using group modalities.

Because this specialized treatment program is unique in Canada, the participants were referred from across the country, although most resided in Ontario. The funding structure of the hospital in which the trauma program is offered does not provide for formal follow-up treatment services. In an attempt to compensate for this, the program staff provide support for discharge planning and, when possible, assist participants to make connections with professionals in their home communities (Wright & Woo, 2000). They also send a discharge summary including recommendations for follow-up to the professional who referred the survivor to the inpatient program. However, many clients find themselves back in their home communities without a clear plan for follow-up care. The study described here examined the experiences of program participants in the first six months following discharge.

Methodology

Thirty participants were selected for this study from the larger study sample of 163 adults with self-reported histories of child abuse. All had completed the six-week inpatient treatment program between September 1998 and February 2000. Detailed methodology for the larger study is reported in an earlier publication (Stalker, Palmer, Wright, & Gebotys, 2005). In summary, participants reported information about demographics; potentially traumatic experiences and abuse history at admission; and completed self-report outcome measures, at five points in time (admission, discharge, and 3, 6, and 12 months post-discharge). The four standardized outcome measures were the Modified PTSD Symptom Scale (Falsetti, Resnick, Resick, & Kilpatrick, 1993), the TSI Belief Scale – Revision L (Pearlman, 1996), the Symptom Checklist (SCL-90) (Derogatis, 1992), and the Rosenberg Self-esteem Scale (Rosenberg, 1965).

The 30 participants for this study were purposefully selected to ensure information-rich data (Patton, 2002). The sample included equal numbers of those who were maintaining treatment gains and those who were not maintaining treatment gains on the outcome measures at three

months post-discharge, in order to understand the experiences of both groups with respect to wellness. Additional inclusion criteria required that participants lived within two hours driving distance from the hospital; therefore, all lived in southwestern Ontario. Participants who had expressed written consent while in hospital to be interviewed at a later point were contacted by telephone; 95% agreed to be interviewed and gave informed consent. The interviews were conducted at approximately six months post-discharge.

Trained master's level social work students conducted the audiotaped interviews in the trauma survivors' homes. Interviews ranged from 1 to 1 ½ hours in length. As the interviews were transcribed, meetings were held with the interviewers to compare questions and responses to ensure that the focus of the research was maintained and the interviews were in depth. The data design was continuously adapted to expand the knowledge base and to ensure the data of interest was emerging (Guba & Lincoln, 1981; Lincoln & Guba, 1985). To minimize the effects of interviewer bias, the interviewers did not know the participants' status in terms of maintenance of treatment gains as assessed by the outcome measures. Although an informal conversational style of interview was taken, interviewers were given a guide to focus the interview on the areas of interest. Participants were first asked to identify what they had experienced as helpful and not helpful during the inpatient treatment; in the second half of the interview, they were asked to reflect on their experiences of what was helpful and not helpful since discharge from the inpatient program. Elaboration and clarification probes were developed to gain a more in depth understanding (Patton, 1990). The questions were open-ended and followed the lead of the participant. Participants were asked at the end of the interview to comment on how they experienced the interview, and they were given a list of community mental health resources that they could contact should they need emotional support. Interviewers also recorded their own thoughts and reactions that arose during the interview and this information was used during data analysis (Lincoln & Guba, 1985). A transcript of the interview was sent to all participants who agreed to receive it; the participants were invited to inform the researchers if they wished to add any comments or correct any errors.

The four authors completed the data analysis based on the interview transcripts. Questions that arose from the data analysis were used to inform and modify the ensuing interview process. The research followed an ethnographic approach (Fetterman, 1989) and the four authors worked together to develop codes. Each transcript was initially read, in its entirety, for meaning and understanding of how each participant was interpreting events (Strauss & Corbin, 1998). Memos were made of the initial meanings and the four authors met to develop categories. Two of the authors then independently reviewed three transcripts of the same participants, coded them, and met to review each transcript in detail until there was agreement on categories and themes. This process was completed once more during the data analysis process. Otherwise, the transcripts were coded separately. As new common and unusual dimensions and themes were identified using constant comparative analysis (Strauss & Corbin, 1998), the four authors met to ensure that the themes were emerging from the data in a meaningful way. Disagreements regarding how we understood the data were discussed until agreement was reached.

Findings

Participants ranged in age from 20–54 years (mean = 40.8). Twenty-five (83%) of the 30 participants were female. They were well educated in that 83% had completed at least some university or college. Gross median personal income level, not including partners' incomes, was between $30,000 and $39,000 Canadian.

Table I. Characteristics of the abuse and psychiatric and substance abuse histories.

Variable*	Category	
Abused as a child ($n = 30$)	Physically, sexually, and emotionally	67%
	Physically and emotionally	17%
	Sexually and emotionally	13%
	Solely emotionally	3%
Mean age when abuse began ($n = 20$)	Physically	4.7 years (SD = 3.6)
	Sexually	6.3 years (SD = 4.0)
	Emotionally	4.6 years (SD = 3.4)
Mean number of traumatic events which resulted in fear of being killed or seriously injured, or being seriously injured ($n = 29$)		4.7 (SD = 2.6)
History of substance abuse ($n = 29$)	Drugs	52%
	Alcohol	52%
Number of Axis II diagnoses ($n = 16$)	None	38%
	One	56%
	Two	6%
Mean total score on Modified PTSD Symptom Scale	Admission ($n = 29$)	70.83 (SD = 20.7; range 17–99)
	Discharge ($n = 30$)	58.7 (SD = 19.45; range 18–100)
	3 months ($n = 27$)	64.74 (SD = 24.05; range 26–104)
	6 months ($n = 25$)	61.0 (SD = 24.31; range 13–94)
	12 months ($n = 22$)	62.73 (SD = 18.61; range 13–90)
Mean number of previous hospitalizations ($n = 28$)		2.2 (SD = 1.79)

*Information was missing for some categories; Axis II diagnoses were not completed for all participants.

Table I displays the characteristics of the abuse and the psychiatric and substance abuse histories reported by participants. All participants reported sexual, physical, and/or emotional childhood abuse. The age of onset ranged from 6 months to 14 years for each type of abuse; however, the mean age of onset for sexual abuse was greater (6.7 years) than that of physical abuse (4.7 years) and emotional abuse (4.6 years). Participants reported between 1 and 10 incidents of trauma where they feared being seriously injured or dying, or where they were actually seriously injured (mean number = 4.7 incidents). The majority of participants reported a history of problems with drug or alcohol abuse. Limited psychiatric personnel prevented every participant from being assessed as to whether they met criteria for personality disorders according to DSM-IV. However, 16 of the 30 participants were assessed by a psychiatrist at the hospital using the Structured Clinical Interview for Diagnosis on DSM-IV, Axis II (SCID II) (First, Gibbon, Spitzer, Williams, & Benjamin, 1997) and 62% (10 participants) were diagnosed with one or more Axis II disorders. The mean PTSD total score as assessed by the Modified PTSD Symptom Scale (Falsetti et al., 1993) at six months post-discharge (approximate time of completion of qualitative interviews) was 61; scores ranged from 13–90. The cut-off score indicating that an individual would be highly likely to meet criteria for PTSD according to DSM-IV is 71 (Falsetti, 1997). Accordingly, at six months post-discharge, 44% of participants in this sample would likely have met PTSD criteria. The mean number of previous hospitalizations for the 28 participants reporting this data was 2.2, with 75% having been previously

hospitalized between one and seven times. All participants had attempted to access mental health treatment services in their communities upon discharge from the hospital.

In order to provide context for the findings regarding experiences with community mental health services, it is important to understand some of the issues with which these clients were coping after they left the inpatient program. The participants talked about a range of feelings and ways of coping that complicated their successful recovery. After discharge, they sought professional help to deal with experiences such as overwhelming affect, shame and guilt, depression, and maladaptive coping strategies.

Overwhelming affect

Many trauma survivors in this study talked about allowing themselves to experience feelings for the first time in the inpatient trauma program: For some, these feelings became overwhelming when they left the program. A male participant noted:

> [The inpatient trauma program] dealt a lot with getting in touch with your feelings and emotions . . . . I was just starting to touch them when the program ended and then all of a sudden I'm sitting home by myself and I've got these emotions [which] would just wash over me and I really wasn't sure what to do with them . . . because, all my life, emotions were a bad thing. And they were quelled and they were squashed and then all of a sudden, here they are and what do I do?

Participants noted that anger was particularly overwhelming. A woman remarked:

> The anger started when I left the trauma program. I had a lot of anger inside of me because I all of a sudden realized that I had to deal with these feelings. I could not suppress them; I couldn't hide them with antidepressants any more, like I had for over 20 years.

Other participants stated that leaving the program itself was difficult because the hospital environment was emotionally safe. Although hospital staff prepared them to leave the program, some found the transition extremely difficult. One participant said:

> I know they tell you at the very end, "now you realize that this is gonna be like jumping off a train, a moving train" – I smacked right into the wall . . . . The analogy of jumping off the train is so appropriate that I wish they could just do something to make it easier, put a cushion out there or something . . . . I remember driving off the [hospital] property . . . and I just started crying. It was like I was leaving home or something – something so secure . . . . It was a combination of leaving something that was very secure and going into the unknown, going right back to [an unsupportive environment]. So, it's – they're absolutely right – it's like jumping off a train.

Shame and guilt

Many trauma survivors in this study also felt embarrassed and ashamed when they left the program because of the stigma attached to being in a psychiatric hospital. One woman remarked:

> It's not something that you would openly discuss with people because it certainly would change their opinion of you. They suddenly doubt your competency . . . losing all respect for me as far as my abilities go.

Participants also felt guilty when they returned to the community if they were not able to participate fully in household, family, or work responsibilities. One woman mentioned that her family had to cut expenses because she was no longer working full-time. Another woman remarked, ''I know that my illness has taken a toll on both of my daughters . . . . I feel really guilty about that.''

Depression

Some participants spoke of becoming severely depressed when they could not meet their own or others' expectations. One woman explained:

> When you get home, other people expect you to be fixed, and I found that a problem because I didn't feel fixed, but everyone's expectations are ''Well you just spent six weeks in the hospital, you must be better now.'' And if you're not, then obviously it didn't work, and so you begin to feel like you failed because you weren't . . . fixed.

Participants also were frustrated when they felt they were not getting better. A woman noted, ''I get very frustrated very easily because I want to be better, I don't want to be sick any more, but the reality is that I am sick and I have to learn how to pace [myself].'' Some would then feel helpless and hopeless. One woman remarked, ''I'm never going to be normal like everybody else and never going to have this health that they say is possible''.

Maladaptive coping strategies

Many participants talked about reverting to old coping strategies upon discharge in order to deal with their overwhelming feelings. A male participant remarked, ''I do an awful lot of numbing, I just turn myself off, I become like an ice field''. Other participants described keeping themselves so busy that they did not have time to feel. A woman said, ''The busier I am, the less I tend to feel and it feels good not to feel because then I'm in control''.

Others discussed dissociation. A woman stated that she dissociated when her feelings became overwhelming: ''Memories keep resurfacing and I try and stick around as much as I can, but sometimes before you even realize it, you're away into a dissociated state''.

Many trauma survivors in this study also talked about harming themselves when they could not control their feelings. A woman explained:

> I cut myself; I'd hurt myself because of stresses at home. My young daughter was running away a lot and was in foster care . . . . I couldn't raise her . . . and when I got out of the [hospital] she started running away more, and staying out over night, and one time . . . I felt like killing myself. I looked towards the balcony and I thought I'd be better off dead and I kept thinking it and thinking it and thinking it until I cut myself. I didn't use anything I learned at the [hospital].

Reluctance to express their feelings to community professionals

Feelings of overwhelming affect, shame and guilt, depression, and the ensuing maladaptive coping strategies were further complicated by participants' reluctance to discuss them with their post-discharge therapists. One woman stated:

If I could just share some of the inner turmoil that I still go through and the thoughts and the horrible feelings and the horrible memories that I still have. If I could share that, I think somehow maybe some of the power of it would go away. But whenever I start trying to talk about things with my doctor — and I mean I have a wonderful relationship with him — I get so scared that I just can't.

Another participant was afraid that if she was too open with her psychiatrist, he would want her to return to the hospital. She explained:

I find him supportive but I always also find I have to be a little bit careful about what I said because I could end up back in a ''psych'' ward again. So I tend to edit sometimes what I say to him . . . . I can't always tell him exactly how bad I'm feeling.

Need for specialized community treatment following inpatient trauma treatment

Many participants emphasized the need for professional support after discharge in order to continue to address and manage their feelings. A woman discussed her motivation to continue her healing process when she left the program: ''If it's something that [was] sort of set up before you leave, while you're still in that whole mind-set of doing it, you [would] come home and you would get into it''. Some complained, however, that appropriate services were either not available or not accessible in their communities. One woman stated, ''I was calling around to everywhere, they didn't have anyone that specialized in this [understanding the traumatic effects of child abuse]. The one place that I found that did was at the university, but you have to pay, and even on a sliding scale I couldn't afford it.''

Many participants remarked that, even when they were able to access services in their communities, the therapist lacked specialized knowledge. A lack of knowledge about the specific techniques used in the inpatient trauma program was particularly problematic for some. A woman explained, ''I can fuel up, say at my therapist's office, but I can't fuel up if he doesn't know what kind of fuel I need. So they need [more] rapport with the [hospital] so that they know how they can help you''.

Others stated that their therapists did not understand the trauma issues. A woman explained:

It is very complex, PTSD is. I had a doctor in [name of another hospital] who 'didn't buy it.' She said that she didn't believe I had it [PTSD]. She said that I had borderline personality disorder. She said she didn't think I had posttraumatic stress disorder and she didn't believe I had manic depression . . . . She wiped out everything that I had [been told], – and said that I had borderline personality disorder.

The quality of their relationship with their therapists was detrimentally affected when participants perceived that their therapists saw them as ''mentally ill'' rather than as suffering the effects of repeated traumatic experiences.

What childhood abuse survivors said was helpful in community-based therapy

Survivors in this study emphasized that it was very helpful when their therapists were knowledgeable about PTSD and trauma-focused treatment. A woman thought that her

doctor was "wonderful" because "she knows all about PTSD". A man was very appreciative that his therapist researched new information and techniques and informed him about them. He remarked, "He's always making me aware – [the therapist said] 'this study came out and revealed this seems to work here, or this was working previously and doesn't seem to work now'. And he just seems to be on top of things".

Participants also explained that the quality of the relationship with their therapists was enhanced when they felt that the therapist was patient and willing to allow them the time needed to work through difficult periods. One woman, referring to her social worker, said, "She's taken me through the whole process. She's been there with me through the crisis, she's seen the good, the bad – she's seen me when I've been highly suicidal . . . . Even with setbacks, I've still always kept moving forward". Another woman was very appreciative when her psychiatrist understood her inability to share her true feelings with him and that he allowed her the time to "keep trudging through".

It was important to abused adults in this study that their therapists were respectful, understanding, and allowed them to work toward their own solutions. A woman explained that her therapist "listens, she doesn't judge me; she just tries to help me. Most of the time I end up helping myself. I guess that's what therapy is about – listening to yourself, and the therapist just saying a couple things and helping you to try to figure it out. But you do a lot of it on your own".

It was also helpful when therapists were open to working with other professionals. A woman remarked that it was very helpful:

> . . . if [her therapist] didn't know what he was doing, or felt like he didn't know enough, he was just so open to making another connection and bringing someone else in, and working with someone else, like as a team. And so, things would go quicker for me, because he would do that, we'd just get through stuff.

Participants also found that they could manage their feelings and behaviour better when they understood how they were connected to the abuse. A female participant explained:

> I was anorexic, and then I had bulimia, and now I'm quite overweight. And I learned recently with my psychiatrist that it's a way that keeps me safe and separated, especially from men . . . . And that explanation fits quite well with me because when I start losing weight I start feeling very uncomfortable.

A male participant noted that his therapist "has been very good helping me get in touch with some of the feelings I'm feeling and understanding why I'm feeling that way . . . and sometimes pointing out the obvious which evades me a lot of times".

Other participants found it helpful to move on from the past and focus on present day issues. A woman stated, "I don't want to go back in my past, I've been there and we've done that and I've done it with him for three years . . . and this is where I'm at now. So we're doing work now on what's happening to me today". Although she continued to be depressed, this woman did not want to address the abuse issues further and it was very helpful when her therapist respected her wishes. Choice was very important to participants when they were addressing their feelings. A woman noted, with reference to her psychiatrist, "She always asks me, and gives me a choice; 'Well, do you want to go this way, do you want to go this way?' So, she makes sure that I'm in control of everything".

Discussion

The inpatient program attended by participants in this study is based on a model of treatment that differs considerably from traditional psychiatric treatment models. Bloom (2000) argues that a trauma-based approach ''serves to normalise symptoms and behaviors that have traditionally been pathologized and viewed as examples of personal and social deviance'' (p. 70). While acknowledging the individual's basic constitutional features, a trauma-based approach primarily views the individual as having been harmed by something or, more often, some person or persons, ''thus connecting the personal and the sociopolitical environments'' (Bloom, 2000, p. 71). Instead of asking patients ''What is wrong with you?'' the trauma-based approach asks ''What happened to you?'' (Bloom, 1997). This shift in understanding leads to changes in expectations of patients and in attributions of responsibility for their care. A trauma-based model expects individuals to learn about the nature of their injuries and to take responsibility in their own recovery (Bloom, 2000).

As we have reflected on the themes that emerged from the interviews with the participants, it appears that most are saying that what they appreciated about the inpatient trauma program, and what they looked for in follow-up care in their home communities, is this important shift in the way their symptoms and distress are viewed and understood. Professionals who were experienced as helpful were those who knew about traumatic stress and PTSD and who could reinforce or teach strategies for managing the intense affect associated with traumatic childhood abuse. They talked about appreciating therapists who shared control and direction of the therapy with them, who gave them choices, and who acknowledged that they had insights and ideas of their own that could help them recover. They found it helpful when professionals could help them see the connection between their current symptoms and behaviour and their history of abuse.

Those who were experiencing the most problems following discharge from the inpatient treatment appeared to be those who were continuing to have difficulty managing their intense affect, or who had begun to experience strong feelings and memories that they had previously avoided. They found it particularly difficult when the professionals they consulted seemed to view them as mentally ill. The fear that they would be perceived as needing psychiatric hospitalization tended to inhibit their ability to share their thoughts and feelings. Rather, they needed their therapists to help them understand that their intense feelings and maladaptive coping strategies were related to the trauma. It is important, therefore, that professionals understand the psychological effects of trauma (Bills & Bloom, 1998; Hetzel & McCanne, 2005; Matthews & Chu, 1997; Twaite & Rodriguez-Srednicki, 2004). Self-harming behaviours and suicidal tendencies, depression, fear, anxiety, shame, guilt, and hopelessness, all of which have been associated with childhood abuse (Boudewyn & Liem, 1995; Brown & Anderson, 1991; Ellason, & Ross, 1997; Hunter, Goodwin, & Wilson, 1992; Jarvis & Copeland, 1997; Long & Jackson, 1993; Low, Jones, MacLeod, Power, & Duggan, 2000), lead to a deteriorated sense of self-worth for the survivor and can be difficult to manage.

Therapists who can teach survivors to use constructive strategies to manage intense feelings and to help them maintain a positive view of self in the face of their symptoms and problems in living are very important to the recovery of adults abused as children (Chu 1994; Mennen, 1992; Saakvitne, Gamble, Pearlman, & Tabor Lev, 2000). Beliefs and affect associated with memories of child abuse and other traumatic experiences appear to be different from the material that non-traumatized clients bring to therapy. They are often filled with feelings of terror, deep shame, rage, extreme guilt, self-loathing and almost

homicidal hatred, and therefore the client requires help in learning ways to moderate the full force of these affects (Pearlman & Saakvitne, 1995).

Participants emphasized that it was very helpful to their recovery process when therapists assisted them to understand their feelings and coping strategies in the context of their specific abuse history. Many clinicians have also suggested that it is important to focus on encouraging a change in how the client interprets his or her symptoms and maladaptive behaviours (Cruz & Essen, 1994; Mennen, 1992; Roth & Batson, 1993). Mennen (1992) stated that it was the therapist's responsibility to reframe the client's responses to the abuse so that they can be seen as coping mechanisms that had been functional to the child-victim in dealing with the abuse, but may not be helpful in present life situations. Cruz and Essen (1994) also emphasized that reframing feelings and behaviour as coping strategies that were adaptive to surviving past abuse can be the beginning of positive change.

Participants in this study supported the tenets of the trauma-based approach when they said that it was helpful when their therapists were respectful, understanding, and non-judgmental. They emphasized that it was validating when therapists followed the direction with which clients felt most comfortable in their healing process as opposed to leading them or pressuring them to follow a specific course of action. In fact, many participants in this study said that it was very important that their therapists encouraged them to come to their own solutions in their own time. Authors writing about the treatment of child abuse also emphasize the importance of following the client's lead in therapy because it is imperative that adults abused as children feel they have some control of the treatment (Bills & Bloom, 1998; Chu, 1994; Pearlman & Saakvitne, 1995; Saakvitne et al., 2000). Having a sense of being in control in therapy is critical because trauma survivors often have never experienced their own agency in terms of having control. It is important, therefore, that therapists recognize the abuse survivor's competence to make decisions and to develop solutions. It is especially important that therapists do not assume that adults abused as children are fragile; they need to refrain from doing for them what they can do for themselves (Slavik, Carlson, & Sperry, 1993). Child abuse survivors have often been taught to attend exclusively to others while dismissing their own needs. Encouraging them to value their own needs, honour their own ideas, and become the directors of their own therapy provides new and healing relational experiences.

Some participants in this study found it helpful when therapists accepted their wish to focus on present day situations, rather than abuse-related feelings. Participants said they found it helpful when they felt that their therapists were following their direction with respect to which therapeutic issues were addressed and when. This helped them to manage overwhelming feelings more successfully because they could decide when and how to address them.

Participants in this study also emphasized the need for therapists to understand the fear and shame connected to the expression of their feelings. Although many participants wanted to talk to their therapists about their feelings, fear about the therapist's response and shame about how they experienced themselves as human beings would stop them from doing so. It was helpful, therefore, when their therapists were patient with them, and willing to wait until the client felt ready to reveal this very painful material. The belief that it was safe to reveal their feelings honestly took time to develop and required a trusting relationship with the therapist. Periodic checking with the client about how he or she is experiencing the therapeutic relationship may be helpful in allowing the client to recognize issues of mistrust and gives permission to talk about what might be interfering with his or her ability to express thoughts and feelings honestly.

Finally, participants in this study would have preferred their therapists to be familiar with the specific treatment approach that the inpatient trauma program provided. Given that this may not be possible for many therapists, it is minimally important that they learn about PTSD and complex PTSD (Herman, 1992; Roth et al., 1997; van der Kolk et al., 2005) related to child abuse and other trauma related issues. We recognize that many communities, due to lack of resources, are not able to provide specialized trauma-based programs. In these situations, it is important that therapists work collaboratively with adults abused as children to assess carefully their therapeutic needs and attempt to develop the knowledge and skills necessary to address those needs. When therapists do not feel that they have the knowledge base to address child abuse issues, and trauma-based services are not available in the community, it is important that they consult with specialists and seek opportunities to develop the necessary skills to provide appropriate services.

An excellent training curriculum for working with survivors of childhood abuse from a trauma framework has been developed (Saakvitne et al., 2000). It is based on the belief that treatment models that approach individuals without taking into account their histories of violence, abuse, neglect, exploitation and other traumatic events ''cannot offer hope or healing'' (p. 1). The authors point out that most mental health professionals have not integrated the new information about the biological, psychological and interpersonal consequences of childhood trauma into their treatment models and their curriculum is an attempt to remedy that situation.

The present study is limited in that it examined the post-discharge experiences of 30 clients from only one inpatient trauma program. It used retrospective self-reports of childhood abuse experiences, which did not allow a detailed analysis of the severity or extent of the abuse. Furthermore, the sample was primarily female, white, and middle class, so it would be useful to explore the experiences of a more representative group of survivors. Nevertheless, this research provides insight into the post-treatment experiences of childhood survivors of physical, sexual, and emotional abuse, and what was helpful and less helpful, in attempting to access community-based treatment services. Although this study examined the experiences of adults abused as children after discharge from an inpatient trauma treatment program, the issues raised are also relevant to the many adult survivors of child abuse who have not experienced specialized inpatient services. Child abuse related issues can become overwhelming for people at various junctures in their lives, whether or not they have participated in an inpatient program. This research points to the need for accessible, affordable, community-based services that use a trauma-based approach. Perhaps, as more helping professionals adopt a trauma-based approach and genuinely listen to what has happened to clients during their developing years, those professionals will be able to foster greater political will to provide the best possible treatment for survivors of childhood abuse in all communities.

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