

New therapy
helps adults
process
childhood
sexual abuse



Putting Away the Past

inda lost her job over a pack of gum.

Each time her boss popped a stick of Big Red into his mouth, he became her grandfather. That simple piece of gum was a trigger that sent her right back to age eight and the nightmare of sexual abuse she endured at her grandfather's command.

This is just one of the devastating stories Kate Chard can tell. "Childhood sexual abuse affects a man's, a woman's entire life," she says. "We focus on some core areas in my therapy of safety, trust, power and control, self-esteem and intimacy. Those things impact ability to work, ability to sustain healthy relationships, and ability to parent.

"We see anger, fear, depression, post-traumatic stress disorder (PTSD), and a tendency to re-experience. When triggered by an event, person or smell, these abuse survivors often disassociate. They're at work, they've got a child at home, they've got friends around, they're having a hard time maintaining their own connection with reality."

Chard, an associate professor in UK's educational and counseling psychology department since 1996, designed a highly successful therapy program—11 years in the making—that flies in the face of what she calls society's "don't cry/don't think about it/get over it" mentality. "If you go through a traumatic event, that's the exact wrong advice. Stiff upper lip? No way!"

Chard created her therapy program as a grad student at Indiana University, piloted it on an internship, wrote the grant as a postdoc, and was funded by the National Institute of Mental Health (NIMH) as soon as she arrived at UK.

"It was the first NIMH-funded treatment outcome study on childhood sexual abuse," she says. This three-year study of women (Chard has done an equivalent study with men) took adult survivors of childhood sexual abuse through a 17-week, manual-based program, with individual or a combination of individual and group sessions, centered on cognitive processing.

"What you think affects what you feel, which, in turn, affects what you do," Chard says, summing up the basic theory behind cognitive therapy. "We build on this by saying that due to the traumatic event, the ability to process cognitively has become impaired. Biologists can look at the neurotransmitter connections in the brain and actually see differences between people who've been through traumatic events, such as childhood abuse, and people who have not."

While she doesn't do any brain mapping herself, Chard says this altered biology makes sense based on the fact that, as

children, we are only just beginning to conceptualize the world by organizing experiences into categories. She gives this analogy, which she uses with her clients: "You see a two-year-old run up to a dog and say, 'Doggy!' And then she sees a cat, and she doesn't have a schema for cat yet, so she says 'Doggy!' Mom says 'Kitty,' but everything four legs and furry is doggy until the child develops more categories.

"And then I look at my clients and say, 'Where's the category for child abuse?' When you're five, there isn't one. The brain doesn't have a place to store that kind of event, so it ends up bouncing around—not stored well at all in terms of a past, processed event. So what we do in therapy is bring it up, process it, make neurotransmitter connections, make sense of it with a new schema, and put it away."

The first step to "putting it away" is dredging it up, in as much detail as possible, but Chard says she purposefully designed her therapy to make this process less painful. Most therapies start with a recapitulation of the event as a first-person, present-tense verbal account, which makes the victims feel like it's happening all over again. In contrast, Chard's program allows them some distance by putting the account down on paper, in past tense.

"They write it at home, and then they come in and read it to me. There's something far less traumatizing in allowing them to hold onto that piece of paper and distance themselves from the abuse," she says. "When you compare our therapy to others, we show far fewer dropouts."

Of the 36 women who started the therapy, only one did not complete the 17 weeks. Chard contributes some of this success to the ability to lay out a clear treatment plan for clients from the start.

"If you were going in for cancer treatment and your doctor told you, 'I don't know how many sessions I'll treat you with, and I'm not necessarily sure of what I'll do next week,' you'd never go back. Cognitive processing therapy is built heavily upon informing the client of what we're going to do, what side effects they can expect, what the outcome's going to be, and what their obligations to the therapy are."

There's lots of homework: writing up the event and completing worksheets to discuss at each session (like the "ABC sheet" that has you write down what happened today, what you told yourself, and how you felt). "It's time-intensive," Chard says. "That's what we tell our clients. You're going to feel worse before you feel better, but you need to be able to put yourself first for 17 weeks."

Graduate Therapists

This study was unique in that all of the therapists, besides Chard herself, were graduate students. “I think that’s one of the neatest things about my therapy because it says you don’t have to have years of experience to be a good therapist for childhood sexual abuse survivors. You just have to be trained in using a model that works.”

Chard’s NIMH grant supported eight doctoral students who had already completed their therapy practicum training. The students sat in on group therapy sessions and watched videotapes of Chard doing the therapy with clients. “After they watched one client all the way through and had been involved in the group supervision for a few months, I assigned them a client and they began videotaping their own sessions,” she says.

“I had a few clients who were reluctant to have a junior therapist, but I explained that they are getting my therapy.” She pulls out a two-inch-thick, spiral-bound manual. “It’s very concrete what they’re going to do and what they’re going to say. And I’m overseeing their work by watching their videotapes.”

Gina Owens, a student who has worked closely with Chard and is in the process writing up her dissertation data on the cognitive processing therapy, says the videotapes are invaluable. “It’s a really good tool for learning, particularly when you’re just starting out. You have on paper what you need to do during a session, but it’s great to have a visual representation of that, just to see how it might play out. It’s neat to watch the different questions that come automatically to Dr. Chard because she’s done this for so long. It helped me see different avenues I could pursue with clients.”

After the students work with two clients, the students become certified therapists. “That was something I built into the grant that the federal government agreed with,” Chard says.

“Our dropout rate is the best in the nation, but so is our success rate at treatment completion and one-year follow-up. We have the best numbers for removing symptoms of PTSD, depression, and cognitive distortions of any therapy for adult survivors of childhood abuse.”

This kind of cognitive processing is effective for all types of trauma (natural disaster, combat, rape, gunshots) but is particularly effective for childhood sexual-abuse survivors, Chard says, because their worldview is tied up in the event.

“We do recapitulation—have them re-experience the event—but we immediately tie that into the cognitions that were developed due to the abuse, and then we empower the client to choose to change those cognitions.”

These cognitions—our beliefs and perceptions—play a key role in shaping our worldview.

“You and I developed healthy friendships with peers and parents, and we developed some healthy cognitions, so even if a trauma happened to us later, we had a healthy base that allowed us to be less impaired by the event. For childhood sexual abuse survivors, because the abuse happened during the time when they’re developing their schemas about the world, they have a tendency to overgeneralize—everything becomes skewed by this event,” Chard says.

“In therapy, we use the client’s own information to provide healthy doses of evidence that contradict these overgeneralizations. For example if she says to me, ‘All men will hurt me,’ I ask, ‘When you came to my office, did you pass any men in the hall-

way?’ The answer’s ‘Yes,’ and I say, ‘Did any of them hurt you?’ ‘No.’ ‘Well then, what does that do to your rule on *all* men? Can we change it to *some* men?’ I’ve just inserted a little bit of evidence.”

Chard estimates that 60 to 70 percent of the women in her study had tried therapy before. “Sadly, the person who had been in therapy the longest, 15 years, had tried many therapists in town and never felt she’d made progress dealing with her abuse,” she says. “We had women ages 18 to 72. There’s no difference in terms of severity of symptoms related to age. Childhood abuse persists.”

Chard says the thing that gets the most attention from her peers when she makes presentations at conferences is her treatment’s success in banishing personality disorders.

“The data I’ve collected shows a large number of personality disorders ‘removed themselves’ at the end of therapy. A lot of people say to me: ‘You think you can treat a personality disorder in 17 weeks—that’s unheard of!’

“I don’t think these people have what I’d call a true personality disorder to begin with. I think what we see in trauma survivors, childhood trauma especially, is that they have maladaptive coping skills. The skills they developed to adapt to that dysfunctional, abusive environment become maladaptive as people grow older and deal with society-at-large, and then they get diagnosed as having a personality disorder.”

By building coping skills, Chard found that these so-called personality disorders disappear, and she says



Kate Chard, an associate professor in UK's educational and counseling psychology department, offers inexpensive and successful therapy to child-abuse survivors for \$5 per session for college and university students, and \$15 for people in the community.

that impacts the whole landscape of treatment.

"My clinician colleagues often base their mode of treatment on whether or not the client has a personality disorder, and that determines hospitalization and medication. What we're finding is that we don't need to put the person in the hospital; often we don't need to add medication. What we need to do is build coping skills through solid therapy."

Chard says the "Push Me-Pull You" from Dr. Dolittle is a good example of the behavior of someone with maladaptive coping skills. "These people very much want to feel connected and loved, but often as children when they would run up to the mother or father to get this love, they were rejected," she says. "Now as adults wanting attention, they run forward to a friend or spouse, and as that person comes forward they

get scared that something negative's going to happen so they run away. And so, the friend or spouse doesn't quite understand why this person who says she loves you is constantly pushing you away."

Maladaptive coping skills often manifest themselves in avoidant behavior. As Chard says, "When a situation gets sticky at home or on the job, there's a tendency to avoid negative feelings. Survivors associate negativity with punishment or sexual abuse, so they avoid people, places or things that will be triggers."

Linda, whose boss just happened to chew the same brand of gum as her abusive grandfather, couldn't work with her boss because she'd flash back and couldn't function. She ended up getting fired. "It's hard to imagine for people who don't trigger, but for sexual-abuse survivors this is an everyday, if

not every hour, experience," Chard says. "But with my therapy we didn't have a single case of someone who didn't get better if they did the homework."

"Every few months a client tells me that her entire life has been turned upside-down, in a good way, because of this therapy," she says. A woman from Madison, Indiana, drove two hours to Lexington once a week for therapy. "I get holiday cards from clients seven years later saying their life is still great."

"I'm not saying I cure everything the client brings to therapy. There are often some marital issues that come up that clients choose to work on in additional therapy, but in terms of the core obstruction of their daily living, we're taking care of removing most of those problems. I can't think of a greater reward than that." ■