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LITERATURE REVIEW

TWO-EYED THERAPEUTIC MODEL

FOR WORKING WITH ADULTS

WHO EXPERIENCED CHILDHOOD SEXUAL ABUSE

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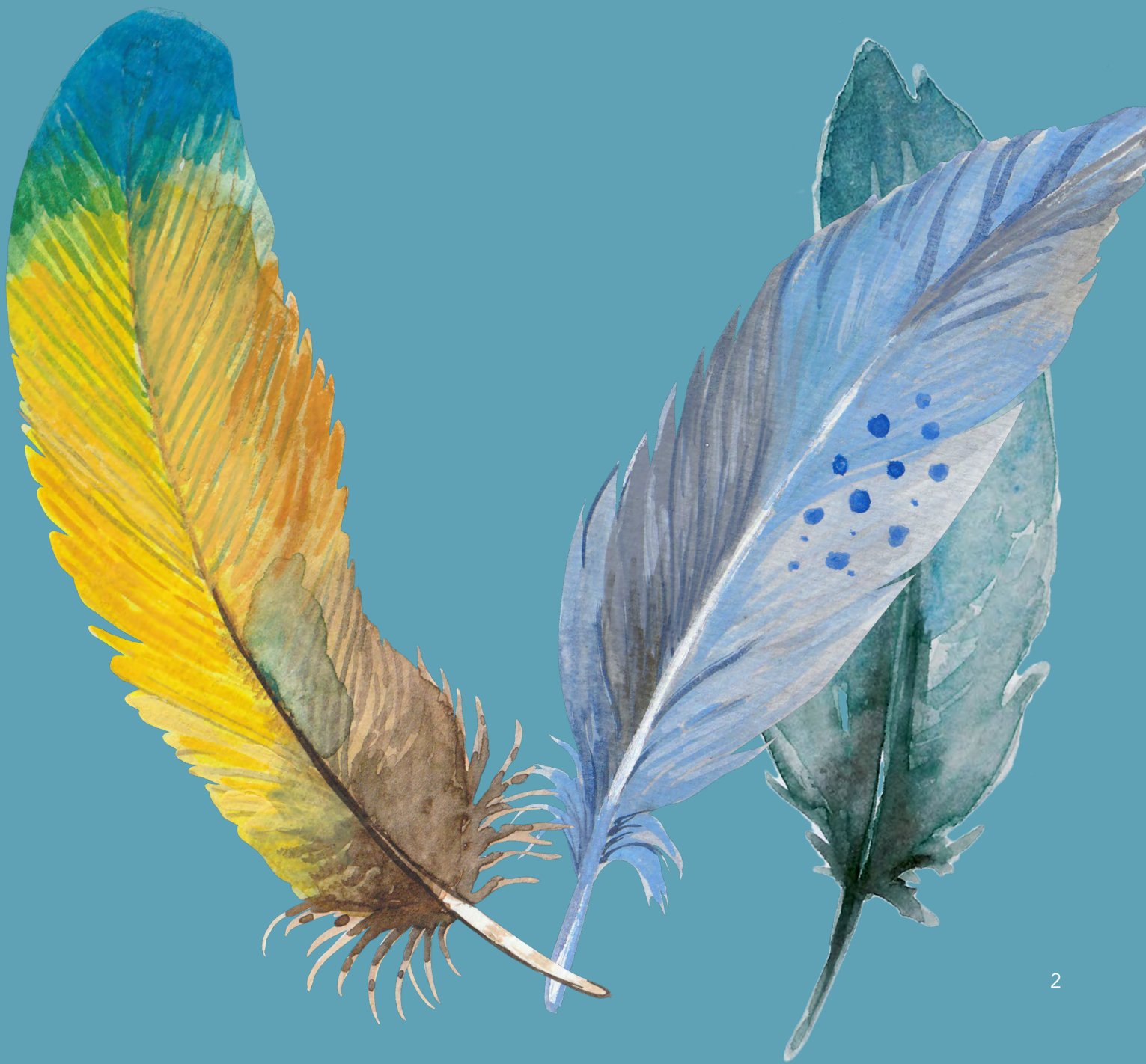

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Introduction

The advancement of research over the last 20 years on childhood sexual abuse reflects the prevalence of this form of sexual violence as a global problem impacting millions of children. Childhood sexual abuse (CSA) is a distinctive developmental trauma that interrupts children's normal functioning and development, which can impact all areas of a person's life well into adulthood. This paper begins with an overview of the preponderance of this issue in Canada among diverse groups and Indigenous populations. It explores the long-term impacts of CSA on mental, emotional, and physical health and then examines Western forms of therapy and their historical implications on Indigenous populations. Finally, this paper proposes that, based on indicators of Two-Eyed Seeing developed through current addiction and mental health services, there is potential for mainstream interventions to be inclusive of Indigenous healing practices that can benefit adult survivors of CSA from diverse backgrounds.

Definition of Child Sexual Abuse

Child sexual abuse is a global issue that affects millions of children, resulting in long-term health outcomes that can follow them well into adulthood. While there are multiple definitions of what child sexual abuse entails, this paper uses the definition from the World Health Organization (WHO) and the Canadian *Criminal Code*. The WHO (2020) provides a global definition to include all forms of maltreatment (physical, emotional, sexual, neglect, and exploitation) by a person in a position of trust, authority, or power that occurs to children under the age of 18, resulting in harm that impairs their overall health and wellbeing (para 1). Specifically, the WHO (1999) Consultation on Child Abuse and Prevention (CCAP) defines child sexual abuse as the following:

> Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or

> satisfy the needs of the other person. This may include but is not limited to: The inducement or coercion of a child to engage in any unlawful sexual activity. The exploitative use of children in prostitution or other unlawful sexual practices. The exploitative use of children in pornographic performances and materials. (pp. 15–16)

In Canada, under the *Criminal Code*, the legal definition comprises any form of sexual contact against a minor (under 18) by threat or by force, intimidation, and/or manipulation, which includes fondling, the invitation to sexual contact, intercourse, rape, incest, sodomy, exhibitionism, sexual exploitation, and pornography (Department of Justice, 2002). This includes approximately 20 different sexual offences, including:

> Sexual interference, the invitation to sexual touching, sexual exploitation, incest, bestiality, child pornography, parent or guardian procuring sexual activity, making sexually explicit material available to a child, luring a child, agreement, or arrangement of a sexual offence against a child, exposure, sexual assault, procuring, trafficking a person under 18 years, voyeurism and indecent acts… (*Criminal Code*, 2022)

There are also specific laws under the *Criminal Code* outlined by the Department of Justice (2017) that include specific standards around consent laws; children under 16 years cannot legally consent to sexual acts. However, there are exceptions where children are close in age. For example, a 12- or 13-year-old can have sexual contact with a partner where the age difference is not greater than two years. Youth between 14 and 15 years of age cannot consent to sexual activity if an age difference is greater than five years. Lastly, sexual exploitation is illegal for youth between 12 and 17; therefore, they cannot consent to sexual acts. In all consent cases, it becomes illegal when an individual is in a position of trust or authority over the youth (Department of Justice, 2017).

Although the definitions provided do not clearly state that CSA is not always physical or includes non-contact sexual abuse, Murray et al. (2014) include attempted sex acts, harassment, exhibitionism, exposing a child to masturbation and pornography, and taking photos or video recordings involving a child of a sexual

nature. Although males and females can experience CSA, there is a greater prevalence of sexual abuse among females, with intersectional factors that pose important considerations for CSA among persons with disabilities, equity-seeking groups, and Indigenous populations in Canada.

Prevalence of Child Sexual Abuse

In 2006, the World Report on Violence Against Children estimated that over 150 million girls and 75 million boys under 18 are subjected to sexual violence, including 1.8 million children exploited through the sex industry or pornography (Pinheiro, 2006). In Canada, identified reports of CSA are estimated at 2.4 million children 0–17 years old, with exposure to some form of sexual abuse occurring before they turn 15 (Cotter & Beaupre, 2014). Other national studies report even higher rates of CSA, estimated to be over 3.6 million, with characterizations of substantial gender differences (Afifi et al., 2014).

CSA impacts females and males in distinct ways. For instance, international estimates specify that females have a higher prevalence of CSA when compared to males (19.7% versus 7.9%) (Stoltenborgh et al., 2011). Similar to international statistics, Canadian national studies identify distinctions based on gender, where reported sexual offences involved 16% of females under 12, with a 34% increase in victimization occurring between 12 and 17 years old (Allen & McCarthy, 2018). **For males, 42% of reported CSA involved children under 12, with a decline in sexual offences (30%) between 12 and 17.** When comparing reports of CSA between genders, males make up 9–10% of reported sexual violations, while females make up 38–39%, a considerably higher rate (Allan & McCarthy, 2018).

Intersectional factors also pose important considerations for CSA. For LGBQT2S+ populations, the definition of CSA is more specifically focused. Xu and Zheng (2015) state that, by limiting CSA strictly to male and female genders, statistical measurements often used in research and analysis restrict the ability to capture the extent of this matter (p. 316). With the limitations in mind, based on international studies, Xu & Zheng (2015) identify that among lesbian, gay and bisexual (LGB) populations (males 22% and females 36%), both males and females experienced higher rates of CSA and were two times more likely to be abused when compared to heterosexuals (19% compared to 7.9%) (Stoltenborgh, 2011).

CSA also impacts persons with disabilities in diverse ways. **Based on global estimates, over one billion people experience disabilities, making up approximately 15% of the world population, with over 200 million representing young people of 10–24 years (Somda, 2018; World Health Organization, 2020).** Internationally, current studies support an increase in sexual victimization where ***"Children with disabilities are almost four times more likely to become victims of violence than children without disabilities, and nearly three times more likely to be subjected to sexual violence, with girls at the greatest risk"*** (Somda, 2018, para. 3). Factors contributing to the prevalence of CSA among children are a violation of human rights connected to societal stigma and discrimination, which perpetuate violence and abuse through systemic barriers (Somda, 2018; WHO, 2020).

Factors connected to increased CSA among children living with disabilities range from cognitive, sensory, and mobility complications that can impact a child's ability to disclose sexual abuse due to limited speech—for example, by not being able to escape their perpetrator or call for help (Kaufman, 2011; Mailhot Amborski et al., 2021). Other circumstances include societal isolation, unsupervised access within institutions and homes, lack of personal autonomy over their bodies, and dependency on others, creating a sense of helplessness and disempowerment (Kaufman, 2011; Somda, 2018).

In Canada, equity-seeking groups include ethnic, linguistic, and visible minorities. **Based on findings from a national study on family violence in Canada, immigrant families reported fewer incidences of CSA when compared to non-immigrant families (6% compared to 9%), and visible minority groups also have lower reports of CSA (5% compared to 9%) (Burczycka & Conroy, 2019).** Factors influencing lower reports of CSA may be associated with fear of government interventions, child protection measures, lack of community support, access to resources, and cultural norms where children are silenced to prevent shame and community backlash, which serves to protect the larger family unit (Burcyzcka & Conroy, 2019; Stoltenborgh et al., 2011).

Among Indigenous populations in Canada, CSA also poses important intersectional factors connected to structural violence, racism, discrimination, and oppression stemming from colonization, the *Indian Act*,

reservation systems, child welfare legislation and the residential school system (Truth and Reconciliation Commission of Canada, 2015). Based on national data, when compared to non-Indigenous populations, Indigenous people overall had increased reports of CSA where they were more likely to experience the most severe forms of sexual violence (13% compared to 8%) (Burcyzcka & Conroy, 2019). When considering gender differences, Indigenous females have higher rates of CSA (21%) than non-Indigenous women (12%). Similar differences are noted among Indigenous males, who experience higher rates of CSA (7%) compared to non-Indigenous males (4%) (Burcyzcka & Conroy, 2019).

Despite the prevalence of CSA in Canada, challenges persist due to underreporting. **Based on reflective studies, only one in 20 cases are reported to the authorities (Hornor, 2010), with the more visible reports of CSA involving severe violent injuries requiring medical attention (Murray et al., 2014).** Possible variables that affect how children disclose CSA can be connected to fear, shame, guilt, honor, self-worth, and feeling responsible for the abuse (Murray et al., 2014, p. 323). Other considerations include peri-trauma factors around the relationship between perpetrator and child, type and severity of the abuse, duration, age, and gender (National Sexual Assault Coalition Resource Sharing Project [NSACRSP], 2011). In fact, Canada's national studies identify that most CSA disclosures occur in adulthood, with only 10% of victims/survivors disclosing the abuse while under 15 (Burczycka & Conroy, 2019). More often, victims/survivors disclose their experiences of sexual abuse outside of CSA-specific resources due to long-term impacts of sexual abuse such as mental health issues, addictions, domestic violence, sexual assault, and homelessness (NSACRSP, 2011).

Long-Term Impacts

Adult survivors/victims of childhood sexual abuse can experience profound long-term implications ranging from social and health problems to medical, psychological, and behavioral outcomes that impact environmental consequences for both men and women (Murray et al., 2014; NSACRSP, 2011; Sigurdardottir et al., 2014). For instance, adults who experienced physical or sexual abuse were more likely to report poor physical health when compared to non-victim/survivors (14% versus 9%) (Burczycka & Conroy, 2019).

Commonly reported issues were chronic pelvic pain, gastrointestinal disorders, migraines, frequent headaches, back pain, and autoimmune disorders (NSACRSP, 2011).

Emotional or behavioral problems can also lead to higher rates of depression, anxiety, suicidality, higher-risk sexual behaviors, compulsivity, hypervigilance, lack of concentration, globalized fear, and substance use dependencies (Collin-Vezina, 2009; Murray et al., 2011; NSACRSP, 2011). CSA can manifest in adults who experience severe psychopathology, including paranoia, psychotic ideation, and post-traumatic stress disorder (PTSD). Borderline personality disorder (BPD) and dissociation can also produce disconnections within a person's thoughts, memories, feelings, and actions (Collin-Vezina, 2009; Honor, 2010; Lev-Wiesel, 2008).

Gender differences and similarities exist when considering the consequences and responses of CSA in adults, with women internalizing—e.g., behaviors related to eating disorders and depression—and men externalizing—e.g., behaviors connected to destructive substance use, aggression, violent behaviors, and delinquency (Honor, 2010). **Martin et al. (2004, as cited in Honor, 2011) report that people who experienced sexual abuse in childhood are twice as likely to be diagnosed with a psychiatric diagnosis than adults with no history of CSA.**

Research consistently shows that child sexual abuse has adverse effects on adults associated with increased re-victimization later in life, connected to intimate partner violence (IPV), sexual assault, sexual exploitation, homelessness, criminal violence, and violent victimization (NSACRSP, 2011; Murray et al., 2014; Sigurdardottir et al., 2014). For instance, both genders with a history of CSA reported an increase in IPV compared to populations with no history. Males reported 17% versus 10%, while females reported being twice as likely to experience IPV (67% versus 35%), which includes more severe forms of violence (beaten, choked, and threatened with a weapon) (Cotter & Beaupre, 2014). National studies correlate CSA to an increase in homelessness among all genders: 15% of survivors/victims reported living in a shelter, on the streets, or with unstable living conditions when compared to populations with no history of abuse (6%) (Burczycka & Conroy, 2019). Additionally, higher incarceration rates were reported in CSA victims/survivors: 50.4% for women and 21% for men (Bodkin et al., 2019).

Indigenous groups in Canada have unique experiences directly connected to colonization, systemic racism, discrimination, and oppression imbedded within federal policy and laws (National Centre for Truth and Reconciliation [NCTR], 2022), which have implications for the long-term impacts of CSA. The *British North American Act* of 1867 governs the *Indian Act*, which had the direct intention of dissolving traditional Indigenous customs and worldviews by severing connections to the land, languages, ceremonies, tribal customs, and natural laws (NCTR, 2022). More notably, assimilation tactics used under the *Indian Act* include the spatial containment of First Nations on reserves and the implementation of federally run residential schools (NCTR, 2022).

For over 150 years, from 1831 to 1996, approximately 150,000 First Nations children aged 7–15 were forcibly removed from their families and communities to attend residential schools across Canada (NCTR, 2022). Of those who attended residential schools, approximately 32.6% reported sexual abuse (Snyder, 2018). Although this rate is similar to what was previously mentioned, the long-term implications are also connected to a history of cultural genocide and intergenerational trauma that exasperates the physical, mental, emotional, and spiritual health of Indigenous survivors/victims of CSA (Marsh et al., 2015).

Despite the unique differences that Indigenous communities face when considering the long-term impacts of CSA, Indigenous and non-Indigenous adult survivors/victims continue to experience a myriad of adverse outcomes that can manifest differently in each person, from mild to severe psychological, behavioral, and socioeconomic outcomes. Therapeutic interventions and treatment modalities can ease the healing of people who experience adverse outcomes of CSA, which can lead to fulfilling and meaningful lives. The following sections provide a brief overview of current Western therapy and treatment modalities and then explore Two-Eyed Seeing, developed through current addiction and mental health models, and its applicability to the treatment of CSA among adults.

Current Therapy and Treatment Modalities in Working with Adult Survivors of Child Sexual Abuse

Despite widely recommended therapy classifications, there is still a lack of evidence-based research for the treatment of child sexual abuse among adult populations. There are currently over 50 therapeutic approaches commonly used in counselling. However, deciding which method works best is challenging due to multiple variables, such as client and therapist personalities, history, personal goals, life circumstances, and therapists' approaches and communication styles (Zarawi, 2020).

Being familiar with multiple models of practice aids social workers and clinicians in determining individualized, group, and familial treatment strategies to achieve optimal outcomes, which often include a customizable blended approach to working with adult survivors/victims of CSA (Gorman, 2013; Zarawi, 2020). For example, despite the lack of evidence-based practices outside of cognitive behavioral therapy, Gorman (2013) highlights common therapeutic approaches used with adult survivors of sexual abuse:

> Critical incident stress debriefing, psychoeducation, exposure therapy, eye movement desensitization reprocessing (EMDR), stress inoculation therapy, trauma management therapy, cognitive behavioral therapy, psychodynamic psychotherapy, hypnotherapy, imagery rehearsal, memory structure intervention, interpersonal psychotherapy and dialectical behavior therapy, trauma work based on the recovery model (safety, remembrance and mourning, and reconnection) based on the work of Herman and Courtois; individual, group, insight driven, narrative and cognitive behavioral therapies; holistic and complimentary approaches such as yoga, auricular acupuncture, mindfulness, massage, aromatherapy and collective community practice. (p. 1)

While many current theoretical frameworks exist, the following section provides a brief outline of standard therapeutic interventions addressing CSA. These theories and methods include, but are not limited to, psychotherapy, cognitive behavioral therapy (CBT), trauma-focused cognitive behavioral therapy (TF-CBT),

dialectical behavior, and eye movement desensitization and processing therapy (EMDR), in addition to Adlerian, existential, person-centered, gestalt, feminist, and family systems therapy.

Therapeutic Interventions

The following is only a summary and does not include all theorists, ideas, methods, and concepts; it explores more typical mixed methods that range from standard to less-common practices (Teater & Kondrat, 2010). Although this paper does not provide a critique, it is essential to point out that therapeutic interventions are value-laden and derive from socio-historical contexts that include barriers associated with cross-cultural applicability (Shafe & Hutchinson, 2014).

Psychodynamic psychotherapy

Psychodynamic psychotherapy, developed by Sigmund Freud, uses four core principles (emotions, thoughts, early life experiences, and beliefs) to identify reoccurring distress patterns and develop coping mechanisms to enhance the quality of life (Cabaniss et al., 2016). The primary goals of psychodynamic psychotherapy are ***"to help people with problems and patterns that lead to unhappiness and dissatisfaction in life uncovering unconscious thoughts and feelings and/or directly supporting function in the context of the relationship with the therapist"*** (Cabaniss et al., 2016, p. 3).

Psychodynamic psychotherapy can effectively address PTSD symptoms associated with CSA (Cowan et al., 2020) due to its focus on expressing emotion, identifying reoccurring themes and patterns by exploring past experiences and interpersonal relationships, and identifying wishes, dreams, and fantasies (Cowan et al., 2020, p. 22). Therapists using psychodynamic psychotherapy target feelings and emotions to be examined in a safe space free from judgement, attending to individual comfort levels to avoid re-traumatization (Cowan et al., 2020, pp. 22–23).

Cognitive behavioral therapy (CBT)

Cognitive behavioral therapy (CBT) is a mix of behavioral and cognitive therapy that ***"postulates that thoughts, feelings and beliefs are intertwined and should be assessed in combination when attempting to alleviate or diminish clients' problems and difficulties"*** (Teater & Kondrat, 2010, p. 142). CBT aims to alleviate or diminish psychological distress and dysfunction by determining the source of a client's core beliefs that result in inaccurate negative thoughts and replacing them with positive feelings and behaviors

(Teater & Kondrat, 2010, p. 145). CBT can be a highly structured approach, with specific action- and goal-oriented assessment and intervention methods (Teater & Kondrat, 2010; Zarawi, 2020). CBT is backed by meta-analytic and systemic evidence-based research that supports significant improvement in associated symptoms (anxiety, fear, depression, PTSD, and substance use) experienced by adults with a history of CSA or sexual assault (Fenn & Byrne, 2013; Murray et al., 2014).

Trauma-focused cognitive behavioral therapy (TF-CBT)

Trauma-focused cognitive behavioral therapy (TF-CBT) is a branch of CBT shown by Murray et al. (2014) to be the most efficacious in treating anxiety and depression symptoms that may accompany PTSD among adult survivors/victims of CSA. TF-CBT specifically focuses on trauma over three phases (Cowan et al., 2020). Phase one involves psychoeducation about the impact of trauma and the development of skills in trauma responses (relaxation) and emotional dysregulation, followed by cognitive processing skills. Phase two can occur over several weeks, focusing on collecting the trauma narrative. Phase three identifies cognitive distortions and negative thought processes.

Dialectical behavior therapy (DBT)

Dialectical behavior therapy **(DBT)** is a client-centered and emotion-focused type of CBT based on acceptance principles and mindfulness practices. Although DBT was developed to treat extreme cases of suicide, it has since become an effective evidence-based psychotherapy that is useful for treating personality disorders, mood disorders, suicidal ideation, and interpersonal conflicts (Robins et al., 2010; Steil et al., 2018). Therapeutic goals are based on a hierarchy to promote acceptance of situations, motivation for change, emotional regulation, distress tolerance, and interpersonal effectiveness (Robins et al., 2010). With a combination of TF-CBT and DBT, adult victims/survivors with chronic CSA-related PTSD can alleviate and ***"reduce their fear of trauma-associated primary emotions, question secondary emotions like guilt and shame, and radically accept trauma facts"*** (Steil et al., 2018, p. 102).

Eye movement desensitization and processing therapy (EMDR)

Eye movement desensitization and processing therapy (EMDR) also falls under psychotherapy; it is designed to alleviate distress caused by traumatic events and memories involving bilateral eye stimulation and/or rhythmic movement (Cowan et al., 2020, p. 24). EMDR focuses on treating trauma and its associated

symptoms by reconnecting CSA survivors/victims to images, thoughts, emotions, and physical responses associated with their trauma (Cowan et al., 2020). The eight phases of this treatment are the exploration of the client's history, preparation, assessment, desensitization, installation, body scan, closure, and evaluation of treatment progress (Cowan et al., 2020). Although controversy exists regarding the effectiveness of EMDR, Cowan et al. (2020) affirm that this method is effective when treating PTSD for CSA among adults.

Adlerian therapy

Adlerian therapy is grounded in Adlerian theory, which posits that humans are naturally holistic, creative, and driven towards achieving goals and finding the direction of their life (Rosen Saltzman et al., 2013; Watts, 2013). This form of therapy recognizes that individuals control their destiny rather than being victims of fate and that humans are influenced more by social forces than by genetic or biological factors (Zarawi, 2020). Adults who experience sexual abuse can experience unresolved feelings related to distorted reality constructs that interfere with the sense of belonging needed to attain success and happiness (Watts, 2013). For instance, Adlerian art therapy can address CSA in adults by integrating multimodal techniques into treatment plans that work with trauma narratives through visual, linguistic, symbolic, sensory, and kinesthetic expression that facilitates autonomy, reconnection, and re-learning to trust their perceptions of the world with them in it (Rosen Saltzman et al., 2013).

Existential therapy

Existential therapy emphasizes universal concepts that apply to all human experiences, including death, freedom, the responsibility to make the best choice, and the ability to develop and find meaning in life (Fisher, 2005; Zarawi, 2020). Therapeutic interventions addressing CSA recognize distortions in one's reality as being coping mechanisms that may be detrimental in adulthood if left untreated as these distortions threaten one's existence and exasperate fear, isolation, and meaninglessness in one's life (Fisher, 2005). For adults who experienced CSA, the existential method is centered on trust and betrayal, examining what internal protective structures exist and understanding dissociative patterns, which may rebuild autonomy and help them re-learn to trust their inner knowledge and beliefs of the world and their environment (Fisher, 2005. p. 26).

Person-centered therapy

Person-centered therapy assumes that individuals are intrinsically positive and might function in their most total capacity within environments that enable them to be healthy, functioning, and productive individuals (Rogers, 1980). Person-centered therapy is grounded in anti-oppressive, strengths-based perspectives that empower and promote individual capacity (Edwards & Lambie, 2009; Teater & Kondrat, 2010). Because of traumatic experiences connected to CSA, a primary goal in therapy is to produce a secure environment free of judgment, grounded in positive regard, harmony, and empathy, constructing a catalyst for individuals to succeed in self-actualization and lead meaningful and productive lives (Edwards & Lambie, 2009; Rogers, 1980).

Gestalt therapy

Gestalt therapy is a humanistic, holistic, person-centered form of psychotherapy that views people as intrinsically striving toward personal growth connected to their environment and culture (Senreich, 2014). A Gestalt therapist specializes in a person's present life challenges, focusing on increasing awareness, freedom, and self-direction by identifying suppressed feelings and learning to trust their emotions (Senteich, 2014; Zarawi, 2020). Within a supportive therapeutic relationship/environment, survivors/victims of CSA can confront blockages connected to their abuse by increasing self-awareness to achieve wholeness (Senreich, 2014).

Feminist therapy

Feminist therapy is psychotherapy rooted in a person-centered and politically informed model of treatment that recognizes systemic discrimination and gender-specific obstacles that create inequalities and oppression among women and equity-seeking groups (Blumer et al., 2013). Within this therapeutic framework, CSA is an extension of patriarchal social norms, values, and attitudes that contribute to the psychological condition of survivors/victims (Blumer et al., 2013). The principles of feminist therapy include a strengths-based personal and political context earmarked by social change, the value of diversity, egalitarian relationships, and recognition of all forms of oppression (Teater & Kondrat, 2010). Additionally, feminist therapy concentrates on empowering women, enacting social transformation, establishing a robust sense of self, restructuring identity through self-awareness, and identifying social factors contributing to internal and external oppression connected to child sexual abuse (Blumer et al., 2013; Teater & Kondrat, 2010).

Family system therapy (FST)

Family system therapy (FST) draws on social systems theory, which posits that the ***"whole of the person is greater than the sum of its individual parts"*** (Teater & Kondrat, 2010, p. 17). The focus of FST identifies family structures, behavioral patterns, functions, processes, and the intergenerational influences of family on individual behavior (Hutchison, 2003; Teater & Kondrat, 2010). Utilizing FST with adult survivors of sexual abuse suggests that family functioning (roles, behaviors, communication styles) contributes to the pathology of an individual (personality issues, PTSD, depression, eating disorders, anxiety, substance dependencies) (Karakurt & Silver, 2014). For instance, within their assessment of family functioning, therapists include variables beyond sexual abuse that contribute to long-term implications for the health and overall functioning of adult survivors/victims of CSA (Karakurt & Silver, 2014). Therefore, FST moves beyond the individual inner psyche to integrate the entire family unit as an agent for change (Teater & Kondrat, 2010).

This brief outline of existing models demonstrates the diversity of healing practices that may assist adult survivors/victims of sexual abuse. Despite the differences in the theoretical frameworks, all highlighted approaches aspire to reduce trauma symptoms among survivors/victims of CSA so that their childhood trauma is no longer central, thus enhancing their quality of life. However, it is also important to highlight how modern therapeutic interventions that emerged within the social sciences have significantly impacted Indigenous populations. By drawing attention to this issue, the remainder of the paper will briefly speak to the need for decolonizing therapeutic interventions and how a Two-Eyed Seeing framework developed in current addiction and mental health services can be inclusive of Indigenous and Western therapeutic/healing practices for adult survivors of CSA.

Two-Eyed Seeing: Indigenous Perspectives as a Therapeutic Model in working with Adult Survivors of Child Sexual Abuse

In the wake of colonization, Eurocentric therapy approaches replaced traditional Indigenous healing practices, which challenged the cultural and spiritual strengths of Indigenous people's capacity to heal (Sibanda & Hlongwane, 2018). The effects of colonization continue to be felt among Indigenous tribes across

Canada. With the discovery of over 9,000 children in unmarked burials at residential schools across the nation, the need for culturally reflective therapeutic services is greater than ever (NCTR, 2022). In acknowledging the colonial ties to modern counselling, the intention is not to perpetuate further divides between Indigenous and non-Indigenous healing practices; rather, the past must be acknowledged in order to understand the future.

History of Two-Eyed Seeing

Two-Eyed Seeing originated from the territory of the Unama'k, Mi'kmaq peoples located in Cape Breton, Nova Scotia. The late chief Charles Labrador from Acadia First Nation shared wisdom about our collective humanity, stating: ***"go into the forest, you see the birch, maple pine. Look underground and all those trees are holding hands. We as people must do the same"*** (Kierans, 2003, p. C4). The trees holding hands is a guiding principle of Two-Eyed Seeing (TES), which was developed by Elders Albert and Murdena Marshal and Dr. Cheryl Bartlett in Cape Breton to address inequalities within Western sciences and has since expanded (Iwama et al., 2009).

TES recognizes the colonial history in Western society's attempted erasure of Indigenous peoples through sociopolitical processes that continue to enforce inequalities that oppress, marginalize, and threaten the health and wellbeing of Indigenous people across Canada (Hall et al., 2015; Iwama et al., 2009). TES addresses the power imbalances ingrained in Western systems and supports the resurgence of Indigenous relationships to land, culture, and language (Hall et al., 2015). By addressing inequalities, the vision of TES can create a common ground where the interweaving of knowledge ***"guides people to consciously choose the most suitable knowledge to act upon,"*** without combining Western and Indigenous concepts (Roher et al., 2021, p. 8). As stated by Elder Marshal, TES is ***"To see from one eye with the strengths of Indigenous ways of knowing, and to see from the other eye with the strengths of Western ways of knowing, and to use both of these eyes together"*** (Bartlett et al., 2012, p. 335).

Two-Eyed Seeing is flexible, with guiding principles contributing to a broad range of projects since its inception in 2004 (Bartlett et al., 2012; Roher et al., 2021). For example, TES's ontology, epistemology, methodology, and axiology can be a guide for life that symbolizes a greater responsibility to future generations,

acting as a catalyst for change and motivation. Furthermore, it is premised on co-learning prospects that are reliant on relationships, respect for multiple ideologies, and recognition that traditions are not static (Roher et al., 2021).

TES also speaks to the wholeness or partiality of knowledge that contributes to a new vision and interpretation of the world, which establishes common ground and a co-existence of knowledge. TES also teaches us about spirituality and the universality of human relationality to larger ecosystems and the cosmos, which affect the mental, emotional, physical, and spiritual parts of the self (Roher et al., 2021). Lastly, TES has contributed to decolonizing spaces across disciplines that promote self-determination and honor Indigenous knowledges and idiosyncratic worldviews (Roher et al., 2021). By prioritizing Indigenous worldviews alongside Western pedagogy, the TES framework is used in research, policy, program development, and service deliverables from Africa, Latin America, Australia, and Canada (Hall et al., 2015; Marsh et al., 2015).

Two-Eyed Seeing and Clinical Interventions

Although there is nothing in the literature that speaks directly to TES as a clinical framework for adult survivors of sexual abuse, programs in the United States and Canada have successfully incorporated Western and Indigenous knowledge in addiction and mental health services for inpatient and outpatient programs (Marsh et al., 2015). **For example, Hall et al. (2015), Marsh et al. (2015), Menzies (2013), Radu (2018), Roher, (2021), and Stewart (2013) discuss the significance of spirituality and holistic healing methods that promote cultural identity and Indigenous concepts of wellness and mental health, which strengthen personal growth and connections to community and family.** Other considerations include culturally specific interventions, theoretical frameworks that reflect cultural diversity, community development, and capacity building (Menzies, 2008; Radu, 2018) in addition to a knowledgeable, adaptable, user-friendly, and dependable continuum of services that address gaps across sectors within government and community organizations (Marsh et al., 2015; Radu, 2018)

Based on the available literature, TES prioritizes Indigenous pedagogy alongside Western therapeutic models that recenter Indigenous healing practices to address power imbalances, evaluate existing dissensions, and use both knowledges to devise holistic individual/group case plans (Hall et al., 2015). For instance, current Western mental health and addiction services do not correlate colonization to the detriments

of health among Indigenous populations. However, a TES framework identifies power imbalances created by colonization and recognizes the implications of intergenerational trauma, addictions, disease, and poor mental health as manifestations of colonialism (Menzies, 2013). Therefore, current TES service delivery models include cultural revitalization in response to the loss of cultural identity and traditions that are protective factors in determinants of health among Indigenous people in Canada (Hall et al., 2015; Menzies, 2013; Radu, 2018).

Cultural revitalization involves holistic approaches inherent in Indigenous healing practices, including land, culture, language, and spirituality, which are often missing from modern therapeutic interventions (Marsh et al., 2015; Menzies, 2013). Current delivery models that include TES frameworks support Western and Indigenous protocols that include formal and informal descriptions of qualifications (education/lived experiences), certifications (licensing bodies/Elder/Knowledge Keeper), and ***"formal systems of accountability, supervision and scope of practice"*** (Radu, 2018, p. 6). More specifically, TES employed in mental health therapeutic models delivers hybrid interventions that are reflective of individual needs (Menzies, 2013).

From an Indigenous perspective of healing, wellness is achievable when our mind, body, spirit, emotions, and interconnections between community and family are in equilibrium (Stewart, 2008). When considering Indigenous healing traditions in tandem with modern interventions, therapeutic programs involving multiple knowledge systems have the potential to be harmonious and complementary (Stewart, 2008). For example, some may require modern one-to-one counselling (individualistic) in combination with land-based programming reflective of Indigenous collective (family, group, and community) healing practices (sweat lodges, sharing circles, pow wows, Sun Dances, drum groups, Full Moons, and potlatches) (Menzies, 2013; Radu, 2018; Stewart, 2008). By incorporating Indigenous and non-Indigenous therapeutic models in practice, a TES clinical model can strengthen the cultural knowledge that decreases barriers to accessing services (Radu, 2018).

TES could reflect a perfect world with a balance of worldviews and perspectives, but there are limitations and essential considerations when looking at TES intervention and prevention models. First, it is

critical to ensure that the oppression of Indigenous peoples is not directly or indirectly perpetuated and to recognize that not all communities have access to comparable resources or connections to Indigenous cultures (Marsh et al., 2015; Roher et al., 2021). TES can also risk overgeneralization, lumping all tribal nations into one group without considering that specific relationships to the land shapes specific collective histories, languages, values, beliefs, customs, ceremonies, and worldviews (Hall et al., 2015; Marsh et al., 2015; Roher et al., 2021). Lastly, direct intervention and prevention policies must reflect Indigenous knowledge and understanding of these differences and problems faced from urban, rural, and Northern experiences (Roher et al., 2021).

When considering the current literature on TES, a TES framework for healing that combines Indigenous and Western interventions could be successful. An environment where adult survivors of CSA can choose from multiple knowledge systems can promote holistic healing practices that are person-centered, trauma-informed, and inclusive, with the vitality of working within a framework that includes ***"all nations and relations."***

Summary

This literature review has identified the prevalence and gender disparities of CSA in Canada, with females at greater risk of experiencing sexual violence across equity-seeking groups, LGB communities, persons living with disabilities, and Indigenous populations. The long-term health implications recognize critical elements of bio-psychosocial impairments that affect individuals regardless of gender, sexual orientation, ethnicity, or race. The implications of CSA can follow a person throughout their life, and Western therapeutic interventions have been and continue to be effective in reducing the physiological symptoms associated with CSA. Although there are benefits to modern therapeutic interventions, there is also a history of oppression connected to these approaches, systematically imposing European values onto Indigenous peoples and contradicting traditional ways of healing from trauma. As a result, Western therapeutic interventions have failed to address the colonial impacts associated with the higher CSA rates linked to social policies under the *Indian Act,* residential schools, and child welfare legislation (NCTR, 2015).

The pervasiveness of colonization continues to affect Indigenous people in Canada, where change is not only needed but is indeed essential to rebuilding the bonds of many nations. A Two-Eyed Seeing methodology centers Indigenous pedagogy alongside Western therapies, drawing on the strengths of both worldviews for the further integration of holistic approaches to healing. Although there is no available literature

on a TES therapeutic model for adult survivors of CSA, treatment and healing programs that focus on the respectful integration of multiple knowledge systems continue to materialize in many nations and geographical locations around the world. The wisdom and teaching offered by Elder Marshal and colleagues are valuable in the field of therapy, lending incredible insight into intervention strategies for child sexual abuse in Manitoba.

Conclusion

Due to the complexities accompanied by the pervasiveness and long-term implications of CSA among adult survivors/victims, therapeutic interventions that focus on Western theory may not adequately address the intergenerational trauma experienced by Indigenous populations in Canada. Focusing on Indigenous pedagogy can reach those affected by CSA, including newcomers, gender diverse individuals, and equity-seeking groups. Community-based research grounded in Indigenous methodologies could contribute to expanding a TES therapeutic framework for adult survivors of CSA and be a valuable endeavor for research, policy, and service deliverables in Canada.

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