I Couldn't Say Anything So My Body Tried To Speak For Me:

The Cost Of Providing Health Care Services To Women Survivors Of Childhood Sexual Abuse

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Tamara's House
Services for Sexual Abuse Survivors Inc.

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centres of excellence *for* WOMEN'S HEALTH
centres d'excellence *pour* LA SANTÉ DES FEMMES

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The Cost Of Providing Health Care Services To Women Survivors Of Childhood Sexual Abuse

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Those promoting participatory action research believe that people have a universal right to participate in the production of knowledge which is a disciplined process of personal and social transformation. In this process, people rupture their existing attitudes of silence, accommodation and passivity, and gain confidence and abilities to alter unjust conditions and structures. This is an authentic power for liberation that ultimately destroys a passive awaiting of fate. When people are the masters of inquiry– the owners of the questions under study– their research becomes a means of taking risks, of expelling visible and invisible oppression, and of producing actions for transformation.

Paulo Friere

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Anne Elliott, Project Coordinator
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Executive Summary

Survivors of childhood sexual abuse (CSA) experience a wide range of physical and psychological symptoms and are users of health care services. Health care services include medical services (such as visits to physicians, medical specialists and chiropractors), hospitalization, emergency room services and prescription drugs. This report details the financial costs of insured health care services for 12 women survivors of CSA over a 10 and 11 year period.

Background

Women consistently show a higher rate of CSA than men. Research suggests that one in three to four females and one in six to eight males have been sexually abused by age 18 (Finkelhor et al., 1990; Holz, 1994). Evidence and anecdotal reports suggest that many survivors use a disproportionate share of health care resources, often without solving the underlying problem.

Purpose and Objectives

The purpose of this study was to determine the cost of health services used by survivors of child sexual abuse, whether insured health care services helped in the healing process and whether there are other means of providing healing which fall outside insured health care services**.**

The study asked survivors to review their health care services costs for a ten, and in some cases eleven-year period; "tell their story" about the medical interventions in focus groups and in one-on-one interviews with the principal investigator; judge whether the medical system helped their healing process; identify what other services helped them in their healing journey and make recommendations about appropriate care for women survivors of CSA.

Research Questions

The research reported here examined the following questions:

- How much did it cost to provide insured health care services to twelve women survivors of childhood sexual abuse?
- Did the insured health care services help in the healing process?
- What other services, other than insured health care services, helped in the healing journey?

Research Methods

The study used a participatory action research design with twelve women survivors of child sexual abuse who self-selected to be co-researchers (CR-survivors) over a twelve-month period. Participants ranged in age from early twenties to early sixties, and represented a wide socio-demographic spectrum. Each of the 12 CR-survivors requested and obtained their 1989-1999 health records from Saskatchewan Health. The principal investigator (PI) worked with the 12 CR-survivors in focus groups and in one-on-one interviews to document their utilization of health services, to measure the costs of these health services and to record their reflections on their interaction with the health care system.

Health care service costs were analyzed and compared to appropriate benchmarks, adjusted where possible for age and gender. Qualitative data on the CR-survivor's experience with health care services and their recommendations for improvements were gathered from interviews and focus groups. The PI analyzed the information using theme and content analysis methods.

Main Findings

The cost of insured health care services for the 12 CR-survivors was 4.1 times the population average after adjusting for age and gender. The average annual cost of publicly funded health care expenditures per CR-survivor was $4,387 as compared to $1,081 for the

population average.

The adjusted utilization-to-benchmark ratios showed that, on average, the cost of medical services used by CR-survivors was 3.7 times the population average. The average costs of hospitalization for CR-survivors were 3.8 times the population average and 76% of the cost of hospitalization was spent on psychiatric care. The average cost of medications prescribed to the CR-survivors was 9.4 times the population average and the cost of their emergency visits was 1.5 times the population average.

The CR-survivors reported that some of the positive consequences of insured health care services included various stabilizing effects such as control of symptoms and the ability to function in society. They reported that the negative consequences of health care services included failure of health care providers to detect CSA which may have led to a diagnosis which overlooked the underlying cause, excessive use of psychotropic drugs, and continued fragmentation of various helping systems including health care, social services, and justice.

The cost comparison for community-based services was hard to measure in part because they are not publicly funded and therefore it is difficult to access the costs. But what we do know is that local estimates indicate the average cost in a Saskatoon hospital is $583.00 per day; it costs $47.00 for a half-hour with a family doctor and $72.00 for a specialist. By comparison, community-based, publicly funded counseling costs an average of $40.00 -$50.00 an hour. The estimated cost to run a fulltime (24 hrs. per day, seven days per week) holistic healing centre focused exclusively on healing from child sexual abuse with eight beds is $205.48 per bed per day.[1]

Implications

The consequences of CSA are costly in both personal and financial terms. The

[1] This amount is calculated by using the annual estimated budget of operating Tamara's House in Saskatoon, dividing the annual budget by 365 days and dividing further by 8 beds. Tamara's House is a non-profit community based charitable organization that, once in full operation, will provide holistic healing for women survivors of child sexual abuse.

increased health care services costs associated with CSA, along with the requests of the CR-survivors for more and easier access (availability) to alternative means of healing call for the establishment of other services and treatment aimed at sustained inner healing, not merely the remediation of symptoms.

While existing information does not allow a reliable estimate of the proportion of the provincial health care budget attributable to unresolved CSA, we can extrapolate the provincial cost based on provincial population number. The population of Saskatchewan is approximately 1 million, half of which is female. Using Finkelhor's findings that as many as one in four women are victims of sexual abuse we can estimate the yearly cost to the medical system in dealing with the CSA of women to be approximately $54,837,500[2].

Recommendations

The CR-survivors recommend that:

1. The Government of Saskatchewan ensure that education on the prevalence, impact, gendered differences and cost of childhood sexual abuse be part of the health care and human service professional educational training. The professional groups include Medicine, Nursing, Social Work, Physical Therapy, Dentistry, Pharmacy, Allied Health Science Programs, Complementary care programs, Law, Education, Theology, and Psychology;

2. Health care and human service professionals include the concept of violence, in particular childhood sexual abuse, as an integrated diagnostic concept in the assessment of clients;

3. Health care and human service professionals pay particular attention to the symptoms associated with CSA which often lead to costly misdiagnosis;

[2] Based on an estimation that 125,000 women in Saskatchewan have suffered childhood sexual abuse (1:4) multiplied by the average medical costs of the CR-survivors ($4,387/yr.)

4. The Government of Saskatchewan fund the development and distribution of a public information package with an educational poster and pamphlets to all health, social services, justice and education providers in the province. The information package should include information on the prevalence, impact, gendered differences and cost of childhood sexual abuse, the public's role in eliminating this crime and the steps to be taken if one suspects it is taking place. In particular:
   a. Such material be made accessible and available to children, professionals and the general public;
   b. Such material make reference to a child's right, under provincial, federal and international law (The United Nations Convention on the Rights of the Child) to protection from abuse and the duty of society to protect children;

5. Professionals who work with and on behalf of CSA survivors be accredited by their professional bodies and governed by a professional Codes of Ethics.

6. The Saskatchewan Departments of Health, Social Services, Justice and Education actively address broad social and economic factors relating to prevention of and healing from CSA and work together on integrated collaborative solutions and services while being cognitive of the gender differences. In particular:

   A multi-sectoral initiative be undertaken to fund and host a national conference on the prevalence, impact and cost of child sexual abuse, its gendered differences and the prevention, detection and treatment of CSA, including complementary/alternative care.

7. Saskatchewan Health, establish a committee to assess the potential of selected complementary and alternative therapies for improving health outcomes and reducing health care costs in the treatment of symptoms resulting from childhood trauma, and to make appropriate recommendations concerning the

inclusion of selected complementary and alternative therapies as publicly insured health services for trauma survivors. The committee should include representatives from Saskatchewan Health, Department of Social Services, and trauma survivors;

8. Saskatchewan provincial funding and budgetary commitments be provided for community-based agencies to provide comprehensive, holistic healing services to survivors of CSA;

9. Complementary/Alternative care workers be licensed under a professional act which will require adherence to a Code of Ethics.

The authors of this Report further recommend that:

10. Participatory action research continue to be funded by Health Canada; such research can make use of the substantial body of knowledge possessed by CSA survivors and could serve as the basis for designing programs of prevention, early detection, and treatment of CSA.

11. Health Canada and other funders provide funding for research into complementary and alternative medical care.

Conclusions

The 12 CR-survivors who took part in this study made extensive use of conventional health care services partially because the services were insured, available, appropriate and accessible. These conventional services, while useful, require additional psycho-social (including complementary) interventions to address the survivor's need for deep, inner, sustained healing from childhood trauma.

Interventions which are targeted towards deep, authentic, inner healing, such as healing centres in the community, could have major positive human and societal

consequences and result in significant reductions in costs associated with the health care, social services, and justice systems. With appropriate reallocation of resources all survivors of CSA are more likely to have access to the help they need.

Introduction

The purpose of the research reported here is to begin establishing benchmark data in order to determine the costs of conventional biomedical care for Childhood Sexual Abuse (CSA) survivors. This report describes a participatory action research project involving a cost analysis of treating women survivors of childhood sexual abuse.

A 1999 grant from the Prairie Women's Health Centre of Excellence enabled Tamara's House[3] to test the feasibility of conducting this project, designed and implemented by a research team and conducted between April 2000 and March 31, 2001. Sandra Burgess, an M.S.W. Practicum Project Student with the Faculty of Social Work, University of Regina was Principal Investigator. Team members included Anne Elliott, Project Co-Ordinator at Tamara's House; Sandi Taylor, Healing Centre Co-Ordinator at Tamara's House; Dr. Ailsa M. Watkinson, University of Regina, Faculty of Social Work; and Diana Decaire, a consumer/survivor.

The team has substantial academic and community experience in the area of CSA. Ailsa M. Watkinson authored a 1994 report–*Needs of Adult Survivors of Child Sexual Abuse in the Saskatoon District*–funded by the Saskatoon District Health Board. It recommended that more money be allocated for counselors in the non-government sector to deal with long waiting lists; advocated an integrated approach involving government, non-government and community agencies; and urged public funding of a safe house for women healing from CSA.

In 1997 Anne Elliott completed a report – *Adult Female Survivors of Child Sexual Abuse, the Need For A Safe House*– as part of her MSW. The research involved interviews

[3] Tamara's House is located in Saskatoon. It is a community-based service dedicated to providing holistic complementary and alternative services to women survivors of CSA. As of May 2002 it is located in a new facility with a broad range of services and financed through fundraising, project funding and governnment.

with women who were in a crisis stage of healing from CSA that had led them to be hospitalized. One finding from this research was the failure of the medical system, in general, and psychiatry, in particular, to address the abuse issues of these 5 women. Instead, diagnoses such as postpartum depression, eating disorders or general depression illustrate the common medical practice of attributing symptoms as a problem of the patient. By not asking about past abuse experiences, doctors and other health care professionals missed the opportunity to engage in an active healing dialogue with the women interviewed in Elliott's study.

Subsequently hired by Tamara's House as Project Co-ordinator, Elliott successfully received research funding from the Health Transition Fund (Health Canada) to test complementary therapies. She formed a research team with Wendy McDermott (a graduate student in Psychology at the University of Saskatchewan) and Sandi Taylor (Healing Centre Co-ordinator at Tamara's House) to conduct this research. The project (January 1999-May 2000) involved 76 female CSA survivors 16 years of age and older. The women self-selected one of three complementary therapies: 32 chose Aroma-Massage; 32 chose Reiki and 12 chose Psychodramatic Bodywork. The research demonstrated direct health benefits for survivors. (Taylor et al. 2000)

Building on this collective experience, the PAR project team looked for twelve adult women survivors of CSA to participate as co-researchers [CR] who would review their medical histories from January 1989-December 1999. The twelve co-researcher/survivors (pseudonyms) were: Jana, Fevra, Mara, Aprila, Maya, Juna, Jula, Augusta, Septembra, Octa, Nova, and Deca. The data the co-researcher/survivors collected detailed their use of medical services, number and length of hospital stays, use of prescription drugs and use of emergency room services. Participants reviewed their medical histories to determine how effectively these services had addressed their sexual abuse issues, in particular whether these services had helped or hindered their healing process.

The purpose of this study was to determine whether survivors of child sexual abuse use a disproportionate share of insured health care services, whether insured health care

services help in the healing process and whether there are other means of providing healing which fall outside insured health care services**.**

We asked the following research questions:

1. How much did it cost to provide insured health care services to twelve women survivors of childhood sexual abuse?
2. Did the insured health care services help in the healing process?
3. What other services, other than insured health care services, helped in the healing journey?

Review of Literature

Child Sexual Abuse (CSA), Trauma and Diagnosis

Kempe and Kempe (1984) define child sexual abuse (CSA) as:

> (1) incest – sexual activity between family members; (2) pedophilia – the preference of an adult for prepubertal children as sex objects; (3) exhibitionism – the exposure of genitals by an adult male; (4) molestation – behaviors such as touching, fondling, kissing, and masturbation; (5) sexual intercourse – including oral-genital, anal-genital, or penile-vaginal contact; (6) rape – sexual or attempted intercourse without consent of the victim; (7) sexual sadism – the infliction of bodily injury as a means of obtaining sexual excitement; (8) child pornography – the production and distribution of material involving minors in sexual acts and (9) child prostitution – the involvement of children in sex acts for profit.

It should come as no surprise, given the definition of CSA above, that children who experience it suffer terrible trauma to their body, mind and soul. Trauma is the source of tremendous distress and dysfunction, and results in the survivor living in a state of high arousal or in continuous survival mode. It is this state of high arousal or survival mode that precipitates the bio-psycho-social problems seen in survivors of war, violence, and childhood sexual abuse.

Sandra Butler, author of one of the first books on incest, introduced the concept of trauma in CSA: child sexual abuse is “any sexual activity or experience imposed on a child which results in emotional, physical, or sexual trauma” (1978, p.5). Women healing from trauma, says Butler (1993), make decisions based on what is bearable at any given moment. When a woman can bear to deal with more of her trauma, she can see her reality more

clearly. But if she is being treated for symptoms without any recognition of the trauma associated with CSA an accurate diagnosis is difficult.

The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment. Herman, a psychiatrist, says survivors may collect a virtual pharmacopoeia of remedies: one for headaches, another for insomnia, another for anxiety, another for depression. None of these "treatments" tend to work well, because the underlying issues of abuse are not addressed (Herman, 1992, p. 118). She asserts that abuse in childhood appears to be one of the main factors leading a person to seek psychiatric treatment as an adult.

Herman believes survivors of child abuse suffer trauma similar to those who are survivors of war. The closest medical terminology for this is "post-traumatic stress disorder". Herman has designed a specific diagnosis which she calls "complex post-traumatic stress disorder". The seven diagnostic criteria include self injury, transient dissociative episodes, sense of complete difference from others, isolation, withdrawal, a sense of hopelessness, and despair (1992, p.121). The first criteria for "complex post-traumatic stress disorder" directly links survivors of war with survivors of sexual abuse:

> [There is] a history of subjection to totalitarian control over prolonged periods (months to years). Examples include hostages, prisoners of war, concentration camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation (p. 121).

Sandra Butler (1993) agrees that survivors of childhood abuse and survivors of war are traumatized. Both might experience amnesia for many years only to remember terrible atrocities years later. For Herman (1992), both war victims and child abuse victims fit under the general "post-traumatic stress disorder." Butler (1993) agrees, but would disagree on the context of the crimes. For Butler, the difference is men are adults and trained for battle; they go as a group with weapons to defend themselves. If they return from war wounded, they are often given medals for bravery and can apply for disability pensions. Women and children, in contrast, are the victims of an undeclared war on their lives and bodies.

Children are powerless to protect themselves from their abusers who are frequently their male caregivers. Abuse for women, occurs not on a battlefield, but in the home. They have no weapons, and women and children will be forced, on threat to their life, to keep the abuse a secret.

Other feminists such as Ellen Kaschak, (1992) oppose the introduction, advocated by Herman, of these diagnostic categories into the Diagnostic and Statistical Manual (DSM). They show how presumed disorders pathologize normal and ordinary reactions that are exclusively or primarily women's (p. 168).

John Briere and Marsha Runtz also question the need for multiple psychiatric labels (i.e., Post Traumatic Stress Disorder, Borderline Personality Disorder, etc.) with the associated stigma and etiologic assumptions. Instead they suggest:

> [T]he more global notion of "post-sexual abuse trauma" to describe these long-term effects. This latter construct refers to "symptomatic" behaviours which were initially adaptive responses, accurate perceptions, or conditioned reactions to abuse during childhood, but which elaborated and generalized over time to become contextually inappropriate components of the victim's adult personality (1994, p. 12).

Post-sexual abuse trauma is a good phrase because it names the exact experience and does not label behaviour as a disorder. Further, it separates victims of war and other atrocities from childhood sexual abuse.

Cost of Violence

Two studies published in 1995 look at the costs of violence against women in Canada. Day (1995) looked at immediate medical, dental and workplace costs, and addressed longer-term health and psychiatric effects, drug and alcohol abuse, second generation effects and long term workplace issues. Day estimated the annual health related costs of violence against women in Canada at $1,539,650,387.00 (one and a half billion dollars), but stressed this is only the tip of the iceberg. If costs for hospital admissions, physicians' services and the women's personal costs as well as the cost of legal and judicial systems (including police services) were included, the total would be many times greater. Day

suggested a more effective use of existing resources would be to spend money on prevention and immediate intervention.

Greaves et al. (1995) looked at "selected economic costs of three forms of violence against women – sexual assault/rape, woman abuse in intimate partnerships and incest/child sexual assault – in four policy areas: health/medicine; criminal justice; social services/ education and labour/employment." The report described, personal and third-party costs of violence against women. These results, even with the incomplete data available, show the profound effect violence has, not only on the lives of Canadian women, but also on governments, institutions and businesses. Annual estimates of the economic costs of violence against Canadian women is over four billion dollars ($4, 225, 954, 322):

Social services/education:	$871,908,583.00
Criminal justice:	$2,368,924,297.00
Labour/employment:	$576,764,400.00
Health/medical:	$408,357,042.00
Total selected costs estimates of	$4,225,954,322.00

Specific health care costs of CSA survivors are not well documented in the literature. Walker et al. used the records of one Health Management Organization (HMO) in the United States, to examine differences in annual health care costs and utilization in women with and without histories of CSA, emotional or physical abuse or neglect. They found women who reported sexual abuse had median annual health costs that were $245.00 greater than costs of those women who were not sexually abused. Women with sexual abuse histories had significantly higher primary care and outpatient costs and more frequent emergency department visits than women without these histories (1999, p. 609).

Disclosure of Child Sexual Abuse

The costs of health care services for women sexually abused as children may be

influenced by when and how they disclose their abuse history. Research on disclosure is unclear about whether "telling" is helpful or not. In many instances children receive unhelpful responses–disbelief, inaction or blame (Finkelhor, 1979).

Active suppression of traumatic experiences over time has been associated with increased physical and psychological symptoms and with higher medical use for injury or illness. It is also associated with greater incidence of disease and overall symptom reporting later in life (Pennebaker & Hoover, 1986). Sinclair and Gold (1997) note that "given the traumatic, intimate nature of child sexual abuse, it is easy to understand why telling someone about it might be difficult". The issue of disclosure is complicated even further by the fact that some survivors do not have full memories of the events. Rather than being unwilling to talk about CSA, they do not yet recall it (Leventhal, 1998: 487). Those who are most in need of telling are often the least able to fully disclose (Sinclair & Gold, 1997).

There is great deal of controversy as to whether practitioners should routinely screen women for a history of CSA. A health care worker's response to disclosure is critical to a woman's sense of trust and safety and requires some knowledge and preparation on the part of the practitioner (Tudiver, et al, 2000). Researchers have argued that professional training on how to ask the questions and how best to respond to patients who have disclosed will make the process less distressing both for the health care professionals and for patients (Sinclair & Gold, 1997). Read and Fraser (1998) suggest that professional training in this area would also clarify the specific, collaborative and complimentary roles for the professional team working with the patient. It may also alleviate some of the costs associated with misdiagnosis (Watkinson, 1994).

Drug Therapy

Drug therapy is used by the medical profession as a means of alleviating the results of CSA. Its use is controversial. In *Women and the Psychiatric Paradox,* Susan Penfold and Gillian Walker trace the history of psychiatry. They noted that psychotropic medication led

to the possibility of early treatment and cure or maintenance and care of mental health patients in their own communities (1983, p. 8).

Kendall (1996) argues that the discovery of psycho-pharmacology led to a situation whereby physicians gained a monopoly over healing by ensuring that the medical model (prescription medication) became the dominant health care philosophy (p. 107). Crucial to the medical model of illness is the assumption that all diseases have a specific cause which can be discovered by examining the body's biochemical and physiological functioning (p.108). Kendall believes that psychotropic drug prescribing patterns are the clearest measures of gender bias in medicine. In Canada, between 67% and 72% of all mood-altering drug prescriptions go to women; likewise, women receive electro-shock therapy almost twice as often as men (p. 109).

How do we make sense of the difference in prescription rate between men and women? A feminist theoretical framework argues this difference is the result of a patriarchal culture reinforcing traditional roles for women. Arguing from a feminist perspective, Penfold and Walker (1983) postulate that women's traditional role is maladaptive and subject to many stresses. If women do not like their role and get sick or depressed, they will be given medication to coerce them into submission. The difference in prescription rate appears to be rooted in the unrecognized stresses of women's traditional role and the pervasive sentiment of women who deviate from, or complain about, their traditional roles as wife, mother, sex object and self-sacrificing nurturer (p. 196).

Community-Based Agencies: Early Proposals

Previous studies indicate that women survivors in Saskatchewan who are in crisis in their healing would prefer to go to a safe house rather than the emergency ward; the latter often leads to admittance on a psychiatric ward (Watkinson, 1994; Elliott, 1997). One aspect of this research was to locate Canadian literature concerning feminist-run safe houses for adult women survivors of childhood sexual abuse, to document the need for and if possible to discover the cost to run such agencies, and determine if these agencies provide services which help the healing process. We located relevant documents from

Charlottetown, P.E.I. - Toronto and London, Ontario.

A Proposal for Charlottetown, P.E.I.

Two documents were produced by a group in Charlottetown, P.E.I., the Survivors of Sexual Abuse/Assault [hereafter S.A.S.]. The first document was a 1988 needs assessment, supported by the federal Women's Program, Secretary of State. The second (1992) was a proposal for a residential healing centre for survivors of sexual abuse/ assault.

The key findings of the needs assessment was the belief among the professionals interviewed that survivors of CSA need specialized services due to their long-term, intensive, psychotherapeutic needs as compared to the needs of the general clinical population. Most of the professionals believed a residential centre was necessary to provide on-going support required for intensive psychological change. Women survivors who were interviewed found services were limited both by time constraints and the professionals' limited understanding of childhood sexual abuse. The survivors of CSA confirmed the need for a 24-hour service (S.A.S., 1988, p. 27).

The second S.A. S. document is a proposal for a residential safe house/centre. It was a significant document for the CSA survivor movement and the first of its kind. The S.A.S. report proposed to integrate residential and non-residential programs and suggested women could stay in the apartment/healing centre for at least six months. The S.A.S. proposal included a cost analysis of the high cost of conventional medical models as compared to the cost of a healing centre. The document argued that the safe house model was more efficient when compared to the cost associated with addiction treatment, psychiatric care, child care and social assistance, which are some of the extra-ordinary expenses incurred by CSA survivors.[4]

[4] With funding from Canada Mortgage and Housing Corporation, S.A.S. purchased, renovated and constructed a 9-unit apartment building as a healing centre. They hoped to have the Healing Centre funded as a 3-year demonstration project by Health and Welfare Canada, however, the project was not funded and the apartments are currently rented to single parent families, without the benefit of healing centre programs.

London, Ontario

Two reports on the needs of adult survivors of child sexual abuse came from London, Ontario. The first, prepared by the Family Service Bureau London, was a "Proposal for Services to Adult Survivors of Child Sexual Abuse." The Bureau found itself with high caseloads of adult survivors of childhood sexual abuse. It reported that forty percent (40%) of all persons served in the Community Counselling Program were women survivors of child sexual abuse (1992).

The London Family Service Bureau submitted a proposal for improved services for survivors to the Sub-Committee on the Needs of Adult Survivors of Child Sexual Abuse, part of the city-wide Coordinating Committee to End Woman Abuse. Key was the recommendation to the Ontario Ministry of Community and Social Services that government funding to medical and mental health delivery systems currently providing services to survivors be reallocated to community-based agencies that were informed by a feminist analysis of the ways that patriarchal social structures contribute to the crime of child sexual abuse (Adult Survivors, 1993).

The document, like others cited here, is a summary of survey findings from service providers and survivors. Commenting on the survey of survivors it states:

> Some survivors reported very negative experiences in hospital emergency rooms and inpatient psychiatric units. Admission to a psychiatric unit adds to the stigmatization and sense of powerlessness survivors already experience. It magnifies the message that it is they who are pathological, rather than the societal structures and values that permit child sexual abuse to occur. Furthermore, hospital admission is very costly. The provision of a safe house with staff trained to respond sensitively and skillfully to the unique needs of survivors would more effectively respond to the needs of survivors in crisis, and prevent many hospital admissions. (p. 3).

The proposal described a new service delivery model for survivors in London and asserted that Family Service London was the best agency to provide it. The London literature proposed a safe house model and described the crisis services needed, including a safe home/retreat centre and a survivor crisis line. Citing the high cost of psychiatric beds (as in the S.A.S. documents), they proposed a facility with 8 crisis beds with 24-hour staff.

Toronto, Ontario

The fifth document was by the Danica Women's Project, Toronto which reported a 2½ year study on the needs of women in crisis from sexual abuse. Like S.A.S. and London Family Services, the Danica Women's Project conducted an extensive needs assessment with service providers in the mental health community as well as with survivors. Using the voices of survivors, the Danica report builds a case for a 24-hour crisis safe house for survivors. They describe what survivors need in a crisis:

> When a crisis occurs in response to sexual violence remembered, women from many different communities require a place to go for help. A place where women will find acceptance and be believed. A place that respects women's courage, strength and hope. A place that does not label. A place where no one tells women what to do or how to be. A place where women can risk trusting again, risk speaking what they know, at their own pace. (p. 24).

Currently, neither Toronto, London or Charlottetown have been able to operate a safe house even though, as the Danica Report says:

> The women who speak through this report issue a clear call for community based, woman-centred, culturally based, non-medical, non-psychiatric and free/affordable service. This would mean a residential retreat for women to go when in need of care as a consequence of the lasting effects of sexual violence (p. 94).

While the literature reports from these three locations in Canada have demonstrated the urgent need for a safe house for CSA healing, no such facility has been established. For this reason it is difficult to make a comparison between costs associated with traditional health care services and the costs of community based services for survivors of CSA. However, a new safe house, Tamara's House in Saskatoon, estimates that to run a full-time safe house will cost $205.48 per day per bed as compared to $583.00 a day per bed in the hospital.

Complementary and Alternative Medical Care (CAM)

As noted above, there is an increasing interest in alternative forms of healing. Various reports have called for specialized services and a 24-hour residential centre with

services for residents and nonresidents (Elliott, 1997; Watkinson, 1994; S.A.S. 1988). In addition two studies on the effects of Aroma-Therapy Massage and Reiki (for survivors of CSA) and another on the effectiveness of Psychodramatic Body® work found that these alternative healing methods used by CSA survivors decreased their anxiety, headaches, back pain, guilt and increased trust, improved their eating habits, sleeping, and self-esteem (MacDermott, 2000; MacDermott, et al., 2001). A more recent study on the use of Reiki as a complement to group therapy for mothers healing from child sexual abuse, confirms the findings of MacDermott. The study also found that Reiki improves parent-child relationships and confidence and, when combined with traditional approaches to healing, is cost-effective (Magnuson, 2002). Preliminary data also suggest the cost of providing these services could be significantly lower than those associated with conventional medically insured approaches. Such studies raise the question: should alternative services, which are considered less costly, be covered by medical insurance?

While our publicly funded health system differs markedly from that of the United States, a recent study entitled "The White House Commission on Complementary and Alternative Medicine Policy" (March 2002), focuses on the need to consider legislative and administrative recommendations to maximize the potential benefits of complementary and alternative medicine (CAM). The Commission sought to balance the public's right to choose among different types of health care and the government's responsibility for ensuring that practitioners are qualified and therapies are safe. The Commission called for more publicly funded and rigorous research into CAM, more co-operation among and between CAM and conventional medicine, and that the education and training of conventional health professionals include CAM and visa-versa. The Report notes that,

> There is evidence that certain CAM practices, such as acupuncture, biofeedback, yoga, massage therapy, and tai-chi, as well as certain nutritional and stress reduction practices may be useful in contributing to the achievement of the nation's health goals and objectives (Executive Summary).

The Commission also noted that vulnerable populations may benefit from a wellness component that includes safe and effective CAM practices (For a listing of the complementary and alternative medicines considered in the Commission's Report see Appendix E.).

Summary

It is estimated that approximately one out of four women have been sexually abused as children. The effects are complicating and lead many survivors in search of medical interventions to assist them in their healing. The cost of the violence in terms of health care expenditures is estimated to be higher than it is for women who have not suffered the effects of CSA. One American study found that the median annual health costs for CSA. women was $245.00 greater than for women who had not been the victims of CSA.

Health care services costs are affected when and if a woman discloses the CSA to her doctor. A common and controversial treatment for CSA is the use of psychotropic drugs. Research has shown that drug therapy is used more often on women than on men.

Feminist organizations around the country have attempted to provide other services for survivors of Childhood Sexual Abuse, services that are considered alternatives to the conventional medical model. Survivors of CSA have been asking for and accessing alternative services; however these services are not covered under the current insured health care services plan.

The following discussion will detail the research and findings of a study into the insured health care services costs associated with the care of twelve adult survivors of CSA. The findings will also discuss the women's concerns and recommendations regarding the health care services they received and suggest solutions.

Methods

Participatory Action Research (PAR)

Participatory Action Research (PAR) is a process of integrating research, education and action. It takes seriously each woman's wisdom and experience in the process of producing knowledge. Participatory action research is a bottom up approach to research. It "combines study and action which respond to the needs of persons who are not privileged or given advantage in society" (Blum & Heinonen, 2001, p. 253). PAR involves individuals who may not be "privileged" but who have experiences that contribute to knowledge. PAR is a political process.

One goal of PAR is to help improve services through the development of policy and programming which are congruent with genuine needs. One author describes the steps participants are to take in the research: "look and gather pertinent data; to reflect by discussing and analysing what is going on; and to plan and act through summarizing, implementing, and receiving feedback" (Stringer as cited in Blum & Heinonen, 2001, p. 253). It might be useful to view PAR as "research on a journey". Healing or recovery from CSA is also a journey. Thus, one goal of the research process undertaken here was to assist a CR-survivor in her healing journey. The research focussed on the experiences of the CR-survivors. Our results reflect the views of each CR-survivor as she examined a ten/eleven-year period of her medical history. The CR-survivors had the opportunity to gather the pertinent data, reflect on it through discussions and focus groups, analyse the data, and take action through recommendations and educational plans.

The study used a participatory action research design with twelve women survivors of child sexual abuse who self-selected to be co-researchers (CRs) over a twelve-month period. Participants ranged in age from early twenties to early sixties and represented a wide socio-demographic spectrum. Each of the 12 CR-survivors requested and obtained their 1989-1999 health records from Saskatchewan Health. The principal investigator (PI), a

graduate student in the Faculty of Social Work, University of Regina, worked with the 12 CR-survivors in focus groups and in one-on-one interviews to document their utilization of health care services, to measure the costs of these insured health care services and to record their reflections on interaction with the health care system.

We used statistical methods to analyze the CR-survivors use of the health care system and the associated costs. Individual health records of the participants were analyzed to determine the utilization and cost of insured health care services which include medical services, hospitalization, emergency room services and prescription medications. The qualitative units of analysis were the stories of the CR-survivors' experiences about using the health care system. Data on the CR-survivors experience with health care services and alternative services were gathered from interviews and focus groups. The information was analyzed by the PI using the methods of theme and content analysis.

Benchmarks

Health care services costs were analyzed and compared to appropriate benchmarks, adjusted where possible for age and gender. Benchmarks were calculated for the four major cost categories: medical services, hospitalizations, prescriptions and emergency room visits. All benchmarks represent best available estimates of costs reimbursed to beneficiaries by the medical plan or the drug plan. All benchmarks are expressed in 1995 dollars, this being approximately the mid-point of the 10 and 11 year period during which patient records were obtained. This should allow the computation of a meaningful ratio of actual costs to benchmark costs in our report. Specifics regarding the computation and estimation of each of the benchmarks are as follows.

The Medical Services benchmark was calculated using the per capita payments for insured services by age and sex of beneficiary. For women age 25-64, this figure was $310 per year per capita (Saskatchewan Health. *Annual Statistical Report, Medical Services and Health Registration Branch*, 1995, p. 15).

The average cost of hospitalization per day for the 12 women survivors of CSA was

calculated by taking the average dollars spent per year on hospitalization ($2,570) and dividing it by the average number of hospitalized days per year (4.4). The average daily cost of hospitalization in 1995 dollars was $584 per day. We estimated the average hospitalization days per year for females in the 25-64 age class by taking the daily average for women 25-44 (.96 days per year) and averaging that with the average days for women in 45-64 (1.357 days per year) (Saskatchewan Health, 1990). The average of 1.357 and .960 is 1.16 days per year. The average number of hospitalization days (1.16) was multiplied by the average daily cost in 1995 dollars ($584 per day). This gave us the benchmark $677 per woman per year. This represents our best estimate of the average cost of hospitalization in 1995 dollars for the 1995 fiscal year for women age 25 through 64.

The benchmark for medications was calculated using the Saskatchewan Health *Annual Statistical Report, Prescription Drug Services Branch*, for the fiscal year ending March 31, 1995. Figures were obtained from Table 2 – Prescription Drug Utilization by Age and Sex of Active Beneficiary (p.18). For females aged 25 through 64, total drug plan payments were $11,705,000. Total beneficiaries among females in this age class numbered 171,000. This translates into an average drug plan payment for women in this age group of $68 per year.

To obtain a benchmark estimate of annual per capita costs of emergency services we used the total special calls and emergency services for the year 2000. This was 692,400. This translates into .69 special calls per capita. Priced at $39.22[5] per visit for 1995, this comes to $26.70 per capita in 1995 dollars.

Participant Sampling and Recruitment

Co-researchers were identified by several means. The PI posted a copy of an invitation to participate on the bulletin board at Tamara's House drop-in and healing resource centre. Personal invitations were sent to those on a survivor mailing list at Tamara's House. The team members forwarded a notice of the research project to a number

[5] This price is based on information supplied to us by Leslie Isberg, Health Information Management, Saskatoon District Health Board. The information she provided showed that the average cost for emergency visits to the three Saskatoon Hospitals in 1995 was $39.22

of helping agencies in the community, and to three psychiatrists known to work with survivors. All those receiving the notice were invited to post it and to refer potential co-researchers. The team also advertised a public information session in the local paper for those who might be interested.

Sixteen women expressed interest in the project. Twelve were selected; four were not included because they did not meet the residency requirement (they did not live in Saskatchewan for the dates under investigation, 1989-1999) or because the project time commitment was too long.

The PI conducted a short introductory interview with each of the CR-survivors. She explained the project would take place in a safe place, that a safe worker would be on the premises for the one-on-one interviews and a safe worker would be in attendance at each of the focus group meetings. The potential co-researchers examined the consent form and reviewed the forms and letters they would complete when requesting their Saskatchewan Health data. The PI also informed them they would receive money for transportation and child or elder care if required.

The women were assured that no audio or videotaping would be used during the project. The CR-survivors understood their rights would be protected by virtue of the consent form, which was approved by the Ethics Review Board, University of Regina (See Appendix B).

Data Gathering

Quantitative data gathering focused on the CR-survivor's personal health care data from Saskatchewan Health. Each CR-survivor requested her own health care services data from Saskatchewan Health. The data were kept by three Saskatchewan Health branches and requests were sent to each one: Medical Services & Health Registration, Corporate Information & Technology, and Drug Plan & Extended Benefits. A letter was sent to Saskatchewan Health with the individual consent forms. The health care services data was received approximately two months later.

The requests generated information about insured health care services. These services included visits to physicians, procedures undertaken and the cost of these services, the number of hospitalizations including length of stay and the cost of their hospitalization. The requests also generated information on prescribed medications and the cost of the insured medications. Data about medical services was available only from April 1990 to December 1999. We received data about hospitalization and prescribed medication for January 1989 to December 1999.

Qualitative data gathering began in late September 2000 with the first focus group. The role of each team member was explained: the CR-survivors were the receivers and interpreters of their own health care services data. The PI was a researcher and recorder. A safe worker was available throughout the project to assist the CR-survivors.

The PI combined an informal conversational interview strategy with a semi-structured interview (Patton, 1990). The PI contacted each CR-survivor when her health care documents arrived and asked her where she would like to review her data and be interviewed. Two survivors elected to have their interviews at home: one for childcare reasons and the other for safety. The CR-survivors opened and reviewed their own health care services data in the presence of the PI. Appendix D summarizes each woman's medical costs.

The CR-survivors and PI sat side-by-side, reviewing the health data report line by line. One CR-survivor has visual difficulties so she brought a reading aid that made the process more comfortable for her. The PI and CR-survivor shared their objective and subjective understanding of the content. It is important to note this review was often painful for the CR-survivor because it brought back the memories of why she had sought intervention.

All but one of the CR-survivors were interviewed twice regarding their health care services data. In most cases the PI spent 3 hours with each woman, decoding the data and reviewing health histories. One CR required only one interview because she had seldom used the health care system. After each interview, the PI summarized the information from

the interview in point form; this information became the starting point for the focus groups where the CR-survivors narrated and made sense of their own medical histories.

During the one-on-one sessions, each CR-survivor was asked: (1) the age she was when she first recalled being abused; (2) the age she was when her healing journey began; (3) the kind of health problems she had experienced since January 1, 1989; (4) what other non-insured healing care she found helpful. These questions set the stage for decoding the medical interventions the CR-survivors had received since 1989 and for determining the benefits of these experiences (see Appendix D). The CR-survivors also discussed other coping strategies used to sustain their healing**.**

Focus Groups

The focus groups provided much of the qualitative data. During the first focus group in September 2000, the CR-survivors shared their various reasons for joining the PAR project. Most became involved because the project seemed achievable and concrete. They said they saw an opportunity to be involved in bringing about changes to the provision of healing services to victims of CSA. Other women spoke of the need to make the experience and awareness of CSA salient for themselves, the helping professions and the public. The CR-survivors also said that participating in research in a safe environment became an opportunity for personal growth, confidence building, and skill development. The women said the research was a healing activity that allowed them to take action by making needed recommendations about healing strategies.

Subsequent focus groups were devoted to distributing the summary of the use and cost of health care services data and to develop recommendations for this study. Each CR-survivor reviewed her data. This was followed by a group discussion. When they had examined their personal Saskatchewan Health data they were able to recreate a medical history for themselves. It allowed the women to suggest better ways of spending health care dollars that could lead to comprehensive healing, and they felt publication of the data would make the health care system aware of the financial as well as the human cost of CSA.

Action

The final component of our methodology was action. Using principles of participatory action research, the CR-survivors explored various options for further action. During the last focus group, they indicated they wanted to continue to meet as a self-help group. They also established sub-committees to deal with advocacy and to work on educational resources for health care and other helping professionals.

One of the reasons for the CR-survivors' high commitment to the project was that they were able to participate in a change initiative. The CR-survivors agreed to continue to meet to develop what became known as "the doll." The doll would be an image put on a poster depicting a woman's body. This doll would display some of the injuries experienced by CSA survivors and the resulting medical conditions that may be associated with it. The CR-survivors plan to develop the doll into an educational tool so it can be used to teach medical students and other health care professionals about the wide-ranging injuries resulting from CSA.

Throughout the research process, the CR-survivors felt comfortable making suggestions about the services they needed throughout their healing journey. Through the formation of sub-committees and a self-help group, the CR-survivors are looking forward to action they can take to help realize the needed changes in services to CSA survivors. For example, the CR-survivors hope to publish a book about their experiences and recommendations for change.

Limitations of the Study

The study attracted only one Aboriginal woman. It did not attract refugee or immigrant women, or women who are physically or mentally challenged. Further, this study did not investigate the helpfulness of the many standard social work interventions which could be used in conjunction with medical and/or complementary interventions.

The data on emergency room visits is incomplete. The data reported upon here was

gathered through the Saskatoon District Health Board and does not include emergency room visits to hospitals outside of Saskatoon. The reported visits do not cover all of the time between 1989 and 1999 due to the lack of records available for this time period.

There is little available data on the costs of alternative services such as complementary services and the costs of running a community-based organization devoted to meeting the needs of victims of CSA. The lack of data in this regard made it impossible to compare conventional health care services costs with those of community based services.

Findings and Discussion

The ages of the participants ranged from 25 to 60 years with a mean age of 42.5 (See Appendix C). All 12 were extremely articulate and knowledgeable about CSA and its related social problems. The group included women who were single, married, divorced, separated or living with a partner. The women came from both rural and urban backgrounds. Ten had completed some post-secondary education, while two had not competed high school. All had lived in Saskatchewan during the dates under investigation 1989-1999.

The CR-survivors were predominately Euro-Canadian women. One CR noted Cree ancestry. Unfortunately this study did not attract women from other cultural or racial backgrounds.

Health Care Service Utilization and Costs for 12 CSA Survivors

Health care services include medical services (such as visits to physicians, psychiatrists and chiropractors), hospitalization, emergency room services and prescription drugs). The cost for health care services for the 12 CR-survivors during the period under review was $565,522 (see Table 1). The average insured cost of conventional health care services for the 12 women in our study was $4,387 per year. These figures have not been adjusted for inflation and do not include several categories of costs such as drugs while in hospital, drug plan co-payments and out-of-pocket services and therapies. Therefore, these figures are an underestimate of the total actual costs.

The health care services costs for the 12 CR survivors was 4.1 times the population average. This is 4.1 times the population average (see Table 2). Adjusting for inflation, the current annual health care cost estimates per survivor are $5,087 in 2001 dollars.

The following discussion examines more closely the cost of three of the four components of insured health care services: medical services, hospitalization, and prescription drugs. The emergency room use data shows that the CR-survivors used the emergency room services 1.5 times the general population. However the costs are based on incomplete data and will not be analyzed further.

Table 1.

Table 2.

Comparative Annual Per Capita Costs of Health Care Services					
Healthcare Utilization	CSA Survivors' Average Units/Year	CSA Survivors' Average Actual Costs (1995$)	Population Average Costs Bench Mark (1995$)	Ratio (Actual to Benchmark)	CSA Survivors' Average Costs (2001$)
Medical Services	40.1 services	$1,140	$310	3.7	$1,322
Hospitalization	4.4 days	$2,570	$677	3.8	$2,980
Prescriptions	1316 doses	$638	$68	9.4	$740
Emergency Room	1.05 visits	$39	$27	1.5	$45
TOTAL	**N/A**	**$4,387***	**$1,081**	**4.1**	**$5,087**

NOTES:

1. All cost figures include only amounts reimbursed by provincial healthcare plans (i.e. medical services plan, drug plan, hospitalization plan).
   * The amount of $4,387 does not include drug plan-co-payments.
2. Excluded from these estimates are several costs including costs of drugs while in hospital, drug plan-co-payments, many forms of non-reimbursed mental health services and out-of pocket costs for complementary therapies.
3. Current cost estimates in 2001 dollars based on estimated average annual inflation rate of 2.5% per year for 1995-2001.
4. All utilization figures represent average annual utilization/cost per capita.
5. With the exception of emergency room services, all benchmarks represent population averages per capita, in 1995 dollars, adjusted for age and gender.

Medical Service Utilization and Costs for 12 CSA Survivors

The CR-survivors used medical services 4892 times in 10 years, an annual average of approximately 40 times per survivor. Table 1 illustrates how the CR-survivors' use of medical services varied dramatically. Over the ten year period under review, one woman acquired 873 medical services while another used only 79. Not surprisingly, the medical services costs for the CR-survivors varied from $2,095 to $23,392 over ten years.

The overall cost for CR-survivors use of medical services was $136,783 over 10 years or an average annual cost of $1,140 dollars per survivor. This is 3.7 times the benchmark

or population average adjusted for age and gender (see Table 2).

Table 3 provides data on the number and type of medical services utilized by the survivors in this study, and the costs of providing those services. General practice, psychiatry, and chiropractic care were the most frequently used medical services, with annual averages per survivor of 16, 11, and 7 visits respectively. Frequency of use varied dramatically. In one particular year, one woman used general practice 95 times while another not at all. One CR-survivor went to a psychiatrist 108 times in a single year, while others did not see a psychiatrist in 10 years. One woman had chiropractic care 74 times in one year, and others did not use it in 10 years. Pathology, diagnostic radiation, pediatrics, anesthesia, and optometrists were also used frequently.

Psychiatry was the most costly medical service utilized, with average annual costs per survivor of $487, followed by general practice at approximately $311, chiropractic at $85, diagnostic radiation at $49, anesthesia at $30, pediatrics at $19, pathology at $14, and optometry at $10 (see Table 3). It should be noted that general practice was the only service used by all the women over the course of the ten years studied.

Table 3.

Most Frequently Used Medical Services and Costs for 12 CSA Survivors between 1989 and 1999				
	Number of Services Utilized		Cost of Services Utilized	
	Total[1]	Average[2]	Total	Average
General Practice	1,891	15.8	37,313	311
Psychiatry	1,358	11.3	58,383	487
Chiropractics	792	6.6	10,168	85
Pathology	216	1.8	1,651	14
Diagnostic Radiation	124	1.0	5,916	49
Pediatrics	94	.78	2,324	19
Anesthesiology	59	.49	3,576	30
Optometry	50	.42	1,241	10
Total Services	4,892	40.1	$136,783	$1,140

1- 'Total' indicates the total of all services or costs incurred by 12 survivors between 1989 and 1999 (10 years)
2- 'Average' indicates services or cost for one woman in one year (total / 120).

Hospital Stay Utilization and Cost for 12 CSA Survivors

Hospitalization, as measured by average annual hospital days, was roughly 3.8 times the average adjusted for age and gender. Over 11 years, women in this study spent 582 days in the hospital. On average, one woman in one year spent 4.3 days in the hospital. This does not include day surgery, such as Dilatation and Curretage or emergency visits. The actual number of hospital days ranged from 0 to 212 days over an eleven year period (see Table 1).

The 12 CR-survivors were admitted into the hospital a total of 69 times, an average of once every two years. The women spent 582 days in the hospital, or an average of 4.4 days per year per individual. Nearly a third (22) of the admissions were defined as psychiatric stays, accounting for 447 days. Seventy-seven percent (77%) of the total number of days the CR-survivors spent in the hospital were psychiatric stays.

Twelve admissions were defined as gynecological, however 10 of those did not involve an overnight stay. Women were also admitted 10 times for gastrointestinal symptoms, which

accounted for 30 days, while eight orthopaedic admissions accounted for 37 days. Five visits were defined as general surgery and accounted for 28 days. The reasons for the remaining visits and days were not specified.

The cost for hospitalization totaled $339,201 over 11 years for 12 women, or just over $2,570 per woman per year. The average annual cost of hospitalization for one woman survivor was $2,570. When compared to the general public at $677 per year, it is clear that the sample far exceeds the 'norm'. Costs were calculated according to the costs at the time of use. If the visits were calculated in 2001 dollars, the average annual cost of hospitalization for one survivor would be $2,980 (See Table 2). The cost of psychiatric care in the hospital was very high, costing nearly $2000 a year per woman. In other words, 76% of the total hospitalization costs for the 12 CR-survivors over 11 years as for psychiatric care.

Table 4.

Hospitalization Utilization and Costs for 12 women of CSA between 1989 and 1999								
	Days		Admissions			Cost		
Type Service	Total[1]	Average[2]	Total	Average	Range	Total	Average	Range
Psychiatry	447	3.39	22	.18	0-5	$258,332	$1,957	$0-59,496
Gynecology	2	.02	12	.09	0-3	3,604	$27	0-1,244
Gastro intestinal	30	.23	10	.08	0-4	20,106	$152	0-3,732
Orthopaedic	37	.28	8	.06	0-3	23,738	$180	0-6,705
General Surgery	28	.21	5	.04	0-2	17,120	$130	0-6,220
Other services	38	.29	12	.1		16,301	$123	
Total	**582**	**4.4**	**69**	**.5**		**$339,201**	**$2,570**	

1- 'Total' indicates the total services of costs incurred by 12 survivors between 1989 and 1999 (11 years)
2- 'Average' indicates services or cost for one woman in one year (total 132)
3- Numbers including decimal points may not add up to total exactly due to rounding errors.

Prescription Utilization and Costs for 12 CSA Survivors

The cost of prescription medication was almost nine and a half (9.4) times the population average adjusted for age and gender.[6] Table 5 shows that over 11 years, the 12 women were given 555 prescriptions, an average of 4 per year, not including refills. Anti-infectives, at nearly one a year, were the most frequently prescribed. Steroids, antidepressants and anti-inflammatories were prescribed approximately once every 2 years. Gastro intestinal medications, benzodiapines, anti-convulsants, neureleptics, and analgesics were also commonly prescribed. In total, women were prescribed 173,739 pills or 1,300 pills per woman per year, mainly anti-convulsants, anti-depressants, anti-inflammatory, gastro-intestinal medications, and neureleptics. Approximately 28% of the prescriptions were psychiatric medications (See Table 5).

The cost for insured prescription drugs over 11 years was $84,184, or about $638 per woman per year. Taking into account drug plan co-payments, the total prescription costs were $105, 637 or $800 per woman per year. Anti-depressants were the most expensive at $24,000, while anti-convulsants, neureleptics, and gastrointestinal medications each totalled more than $10,000. The drug plan paid the most for anti-depressants, which cost the most (due to the number of prescriptions, not necessarily the unit cost of the drug). Table 5 describes the costs and use data in more detail.

[6] This calculation, based on the benchmarks (Table 2) does not include the extra amount of money spent by the consumer. It is based on the amount paid by the insured drug plan.

Table 5.

Prescription Drug Utilization and Costs for 12 CSA Survivors between 1989 and 1999									
	Prescriptions			Cost of Prescriptions			Amount Paid by Drug Plan		
Med. Type	Total	Ave	%	Total	Ave	%	Total	Ave	%
Anti-infectives	125	0.95	28	3,649	27.64	3.5	2,380	18	2.8
Steroid/Hormones	64	.48	11.5	7,886	59.75	7.5	6,313	48	7.5
Anti-depressants	62	.47	11.2	23,979	181.66	22.7	16,898	128	20.1
Anti-inflammatorys	62	.47	11.2	8,088	61.27	7.7	7,200	55	8.6
Gastrointestinals	50	.38	9.0	11,612	87.97	11	10,763	82	12.8
Benzodiazapines	40	.30	7.2	1,924	14.57	1.8	1,424	11	1.7
Anticonvulsants	26	.20	4.7	18,563	140.63	17.6	11,451	87	13.6
Neureleptics	26	.20	4.7	16,696	126.48	15.8	16,209	123	19.2
Analgesics	21	.16	3.8	2,124	16.09	2	1,999	15	2.4
Others	79	.60	8.7	11,116	84.22	10.4	9,548	72	11.3
Total	**555**	**4.2**	**100**	**$105,637**	**$800.28**	**100**	**$84,184**	**$638**	**100**

Summary on Health Care Costs

The insured health care costs connected with the 12 CR-survivors' search for health were 4.1 times that for the general population. Within our definition of health care services are medical services, hospitalizations, emergency room services and drug prescriptions. The significant findings in this study showed that the average cost of medical services (visits to physicians and other health care professional) used by the survivors was 3.7 times the average cost of medical services for the general population, adjusted for age and gender. The average cost of hospitalization for survivors was 3.8 times the population average, with the majority of the hospital stays being in psychiatry. The drug plan payments for medications prescribed for survivors were, on average, 9.4 times the average drug plan expenditures for the general population (See Table 2). While the sample of survivors used to calculate these average expenditures is small, the findings suggest that health care costs for CSA survivors are substantially higher than average.

Many of the CR-survivors were surprised by the costs they had incurred over the 10-11 year period under review. The data relating to cost generated a great deal of discussion in

the focus groups. Some of the CR-survivors thoughts about costs and the help they received are reflected in the following comments:

Weird, shocking to read about your life in black and white and see or acknowledge how bad it really was. Almost all of my medical costs are related to child abuse and CSA.

Mixed feelings – [my story] is so awful. In a deeper way, reading it helps me, to accept what happened. It is believable and has to be read from the heart as well as the head. When others [government officials and medical people] read it perhaps they will see why files are so thick and so expensive. I'm so tired of bouncing between four or five agencies.

Shocked at the cost but it feels good to have the story in black and white. It's concrete; it cannot be denied. If government officials can see high costs maybe they would be willing to fund less expensive options too. If not, governments and policy makers are supporting systematic denial of child abuse.

The data makes the cost real for me. It's hard for me to read my data because it is a crazy story but it is my true story.

The cost of care is cheap considering the damage done to me and society's lack of response.

I have used a lot of medical help over the last ten years, but I had no youth, and I still have a lot of recovery work to do. The medical system needs to be able to co-ordinate with holistic care.

I had mixed feelings, hard to read it. It hurts in the heart and the gut. In a deeper way, it allows me to accept and validate what happened to me and my struggle to recover. The cost relates to not being believed about the real problem of CSA and having just surface symptoms treated. The medical system and government will be able to see – in one place – the cost of and despair in the healing journey.

High cost in treating CSA, now the government can see it. Twenty-five percent of the female population have been sexually abused as a child. The long-term dollar costs are phenomenal!

I used a lot of services and it cost a lot over the last 10 years but I still have a lot to get straightened out. I lost my childhood and youth. I got better help from a private counsellor but I could not afford it. I was referred to a psychiatrist. I got pills, they help.

Do Health Care Services Help in the Healing Process?

Three themes emerged from the focus groups and one-on-one discussions around the question of whether the health care services helped in their healing process. The first was the CR-survivors' concern over the inadequacy of medical and other health care providers' training and practice regarding the extent, impact and needs of survivors of CSA. This lack of awareness among the helping professionals caused the CR-survivors distress and the health care system a great deal of money. The second theme was their concern over the extensive use of medication and the third, the lack of integration among public services in dealing with CSA.

Five of the CR survivors expressed frustration over the fact that no medical personnel asked them whether they were victims of child sexual abuse:

> *In all my 57 years of search not one of my "professional caregivers" ever bothered or knew enough to suspect the underlying injury.*

Another CR-survivor reported that even though she was a battered and sexually abused child, she was never asked by any of the doctors she saw whether there was any family violence in her life. In contrast, one CR-survivor was asked by her doctor about violence in her life while the perpetrator was with her in the doctor's office.

Not asking the right questions at the right time can lead to misdiagnosis. Jula acknowledged that the vast majority of her physical health problems were a tangible and more acceptable way of seeking help to deal with the effect of being abused. She said she needed someone to ask the tough questions or at least consider that she might be being abused. She said:

> *I couldn't say anything so my body tried to speak for me.*

She also commented on the effect of not being asked the tough questions:

> *My family spent thousands of dollars taking me to specialists, paying for medications and caring for me when I was unable to work or go to school. I was unable to work*

> *for several months and had to discontinue university. My flashbacks were misdiagnosed as partial complex epilepsy, resulting in my losing my driver's license and my job . . .*

Her total health care costs for the period under review were $30,554, at least two and a half times the population average. Fevra added "hospital stays help medical results of abuse but not healing from abuse." Fevra's total health care costs were $47,702, approximately 4 times the population average.

Others CR-survivors described what they considered to be inappropriate treatment at the hands of medical staff. They questioned whether the "helping professionals" were bound by a Code of Ethics. At some point in her healing journey Aprila was placed on a psychiatric ward where a nurse told her she had demons in her head and she would get better if she became a Christian. She also described a recent contact with a physician who was "*insensitive, revictimizing and ignorant. He cut me off while I was trying to tell him my story, just like my stepmother cut me off.*"

Septembra said

> *I've told health workers in the past about some of my dilemmas and been laughed at. That's where the health system failed me 20 years ago. They didn't seem to believe the severity of my case or didn't know how to handle it or maybe a bit of both.*

A number of the women described birthing as an especially traumatic event. Jana did not want to be left alone with any of the birthing staff; she felt out of control. Juna expressed similar feelings. She felt she was giving over control of her body to someone else for the birthing of her child. By the time her next child was born she hired a midwife for the delivery. One CR-survivor was single at the time of her child's birth. She believed she was treated badly by what she described as "judgmental staff."

Approximately half of the women considered the health care services they received for their medical problems to be satisfactory. The other half rated the health care services as barely satisfactory. However nine of the twelve women described the CSA care, that is health care services focusing directly on the impact of CSA, as unsatisfactory. Jula said,

"I have flashbacks – relive the abuse in hospital and they say these are delusions. I need someone to help me who knows the difference."

Of the nine who found the CSA care unsatisfactory, five had disclosed to their doctor within at least the last eight years that they were victims of CSA. The three who found the health care services satisfactory pertaining to their CSA had all disclosed their childhood sexual abuse to their doctor.

The CR-survivors were hospitalized 3.8 times the population average, with the majority of the hospital stays being in psychiatry. One woman spent 111 consecutive days in hospital on the psychiatric ward. The CR-survivors felt that psychiatric diagnosis often fails to detect and/or treat core issues. And further, there are no discharge plans. Psychiatric Services paid the equivalent of 1 year of my wages to keep me in hospital for 44 days and I was medicated happy so I still have to pick up the pieces.

Only one of the CR-survivors took medication as prescribed. Two said they did not need the medication when prescribed but really needed something else (i.e. some other kind of support). Three stopped medications because of unpleasant or dangerous side effects. Two noted they did not have the money to purchase the medication, so did not. One CR-survivor, who was on social assistance, said the Department of Social Services told her that they would not pay for her medication. Their refusal to pay for her medication "knocked me off course." Five CR-survivors felt the medications might be addictive and they were afraid to use them. Several felt having to take medication was a sign of personal weakness and a blow to their self-esteem. One CR was adamant she should not take medication to treat a societal illness (CSA) but rather the perpetrators need the medication and social policy makers need to take the appropriate intervention. Three of the 12 CR-survivors rated the use of medication satisfactory in their care. The rest found the drugs to be unsatisfactory. It is interesting to note that the three who found the prescriptions useful were the same three who found the medical care satisfactory.

Three of the women mentioned the services at Adult Mental Health as particularly helpful to them. Adult Mental Health is part of Saskatoon District Health and is therefore an insured service. Our cost data did not examine the services provided by this agency.

The CR-survivors used chiropractic services extensively. Chiropractic services are available through self-referral and with subsidized access. The CR-survivors said they used chiropractors not because they needed skeletal re-adjustment but because it was somewhat helpful and approximates the massage therapy they would have sought had it been available at reduced or no cost.

The final recurring theme arising from the discussions and focus groups was the lack of co-ordination among public services. As one CR-survivor noted, the problems associated with CSA result in survivors being unemployed, isolated, and under-educated. Many find themselves seeking the services of Social Services for financial assistance, Justice for retribution, and Health for healing. But as noted earlier, one department, for example Social Services may refuse to fund some medically prescribed medications associated with CSA. They may not know the reasons for the medication. It seems, as one CR-survivor pointed out, that the professional systems work against each other. Mara said it was Child Protection Services that let her down in the first place. They did not intervene when she believed they knew she was being abused. Now she is caught in the health system seeking a "cure" from the effects of CSA.

Fevra wondered why it was not the government that asked what it costs to treat CSA. She said

> *"is this a bureaucratic systemic denial of CSA by Health, Education, Social Services and Justice, a way to keep CSA hush-hush and revictimize survivors through inaction and unawareness".*

The CR-survivors felt they took their healing journey unaided and often misunderstood. They discussed how the largest responsibility for intervention in CSA matters went, by default, to the medical system when early intervention was not upheld by the Departments of Social Services or Justice.

Healing with Other Care

The CR-survivors said they spent a lot of time and energy searching for a safe place

to heal. They said healing is something that happens 24 hours a day. It does not keep office hours and major healing episodes can happen at any time. Natural healing does not lend itself to bureaucratized conventional office hours, such as a 50-minute psychotherapy session.

> *When I phone for help, I need it now – no matter what the cost. There is no triage system for victims of psychogenic trauma.*

Seven of the women sought counseling from counseling agencies that charged some type of fee. One CR-survivor has amassed a large credit card debt seeking counselors.

Over half of the CR-survivors listed alternative types of therapy that they found helpful in their healing. These included Bioenergetics therapy, aromatherapy, massage therapy, Reiki and the services at Tamara's House in Saskatoon. Chiropractic therapy was used by eight of the women. They said that since complementary and alternative therapies such as massage, Reiki and Therapeutic Touch are not covered by the Saskatchewan Medical Care Insurance Bureau they used chiropractors because the cost of their services were supplemented.

The use of complementary and alternative therapies and inexpensive means of accessing services was a high priority for the CR-survivors. One woman said she needs more help than medical and psychiatric care offer. She said:

> *I believe my costs would decrease and healing would be a faster process if I had more access to Tamara's House (i.e. evenings). Knowing that you have a safe place (where you are not compartmentalized into 50 minutes) is real good to know especially if you feel like you're going to fall apart. You have support.*

Many of the CR-survivors spoke about the need for an agency that is open "24/7". A place where one can go to process feelings, calm down, and feel safe. We do not have a clear picture of the costs associated with community-based organizations that provide services to women survivors of CSA. Our literature review indicates that there have been four different studies calling for the establishment of publicly funded holistic and integrated services for women survivors of CSA. Instead there are a large variety of services offered

by various agencies that require the female survivor to search for community-based services. The costs of the services vary.

In Saskatoon, the average cost of private, unsubsidized counseling is $60 to $100 per hour. Community-based counseling is often on a sliding fee scale and is typically $45 per hour. The cost of shelter at the YWCA is $42.00 per day (not including food) and the per diem rate paid by the Department of Social Services to a woman's shelter in Saskatoon is $57 a day.

Perhaps a better indication of the cost of providing community-based care can be found in the budget estimates of a project currently under development in Saskatoon. The project, Tamara's House, is designed to provide integrated and holistic healing to survivors of CSA. Based on budget estimates, the cost of running the 24-hour facility with 8 beds, a healing center and associated supports is $205.48 a day. Tamara's House is the only fulltime community-based service in Canada whose mandate is to provide holistic complementary and alternative services to female survivors of childhood sexual abuse.

Recommendations

The CR-survivors made a number of recommendations for improving the healing services provided by the health care system, public agencies and government. Included in their recommendations is a request for public funding, perhaps health care funding to cover proven complementary and alternative care and to fund holistic healing centres for victims of childhood sexual abuse. The recommendations are grouped under the headings of Training and Education; Co-ordination of Services; and Complementary/Alternative Care.

Training and Education

One of the major themes emerging from this research included the collective concerns raised by the CR-survivors about what they saw as inadequate medical training of all health care and helping professionals regarding the extent and effects of CSA and the needs of survivors. According to current research one in three or four women have been the victims of CSA. And as this project shows, their health costs can be 4.1 times the population average, adjusted for age and gender. The impact of childhood sexual abuse is costly to the health care system and to the productive lives of the survivors. It is an ongoing issue facing many children today. For these reasons alone, health care professionals must be educated about the prevalence, impact and cost of CSA. While this study focused specifically on health care, the CR-survivors called for similar educational information and training to be provided to all human service providers. In addition many of the CR-survivors expressed concern regarding the lack of ethical standards governing those who work with adult survivors of childhood sexual abuse. They called for accreditation and safety criteria.

Therefore it is recommended that:

1. The Government of Saskatchewan ensure that education on the prevalence, impact, gendered differences and cost of childhood sexual abuse be part of the health care and human service professional educational training. The

professional groups include Medicine, Nursing, Social Work, Physical Therapy, Dentistry, Pharmacy, Allied Health Science Programs, Complimentary care programs, Law, Education, Theology, and Psychology;

2. Health care and human service professionals include the concept of violence, in particular childhood sexual abuse, as an integrated diagnostic concept in the assessment of clients;

3. Health care and human service professionals pay particular attention to the clustering of symptoms associated with CSA which often lead to costly misdiagnosis;

4. The Government of Saskatchewan fund the development and distribution of a public information package with an educational poster and pamphlets to all health, social services, justice, religious and education providers in the province. The information package should include information on the prevalence, impact, gendered differences, and cost of childhood sexual abuse, the public's role in eliminating this crime and the steps to be taken if one suspects it is taking place. In particular:
    a. Such material be made accessible and available to children, professionals and the general public;
    b. Such material make reference to a child's right, under provincial, federal and international law (The United Nations Convention on the Rights of the Child) to protection from abuse and the duty of society to protect children.

5. Professionals who work with and on behalf of CSA survivors be accredited by their professional bodies and governed by a professional Codes of Ethics.

Co-Ordination of Services

The CR-survivors cited many incidents of public services working at odds with one

another. Social Services, Health, Justice and Education are important public services and especially so for CSA survivors. Due to the trauma of CSA, many survivors are unable to work and study. As one CR-survivor noted, the problems associated with CSA result in survivors being unemployed, isolated and under-educated. Their interaction with these public services is also costly. CR-survivors have expressed overwhelming dissatisfaction with the lack of partnership between inter-sectoral agencies and services. Part of this dissatisfaction has been the lack of integration. Services are highly fragmented and a woman's healing process is thus broken into many pieces, upsetting the sense of coherence in the healing process. One study has shown the annual estimated costs of violence against Canadian women are over four (4) billion dollars (Greaves et al., 1995).

Therefore it is recommended that:

6. The Saskatchewan Departments of Health, Social Services, Justice and Education actively address broad social and economic factors relating to prevention of and healing from CSA and work together on integrated collaborative solutions and services while being cognitive of the gendered differences. In particular:
   A multi-sectoral initiative be undertaken to fund and host a national conference on the prevalence, impact and cost of child sexual abuse, its gendered differences, and the prevention, detection and treatment of CSA, including complementary/ alternative care.

Complementary/Alternative Care

A common theme in all discussions with the CR-survivors was the need for a "one-stop service" that would work with them in all of the stages of their healing journey. A place of healing that does not work on a "nine-to-five" schedule but is available every day, all day. They called for a "partnership" in healing. This partnership would provide publicly funded complementary and alternative care in the same way we currently provide publicly funded health care. There is now considerable evidence suggesting that selected complementary approaches such as Reiki, aroma massage, psychodramatic bodywork, and other complementary interventions are desired by CSA survivors and that these methods

appear to yield significant benefits in terms of addressing both symptomatic complaints as well as underlying causes. Preliminary data also suggest the costs of providing these services could be significantly lower than those associated with conventional approaches. Research is showing positive results from complementary and alternative therapies for CSA survivors and according to our own preliminary estimates, it is a less costly way of providing services. Such community-based services, as recommended by the CR-survivors, must be provided by properly accredited professionals.

CSA survivors are heavy users of health care. This translates into an extremely high drain on both human and financial resources in the health care system. Survivors are heavy users of all social systems including justice, social services, and education. However, relying solely on bio-medical therapies is of questionable efficacy. Alternative settings have been shown to be promising, although the specific cost differentials between conventional and complementary community settings have not been fully explored due to the lack of data on the latter.

A community-based agency can offer a survivor care that complements medical treatments. If staff and volunteers are warm, open and well trained, they will create an atmosphere that promotes healing. Likewise, a community-based agency can act as an advocate for a survivor who may be having trouble with another agency or institution that she cannot deal with on her own. Many survivors want, and need, traditional medical services, but they want and need treatments such as massage or Reiki. Also essential are affordable counselling that is available without long waiting lists, and 24-hour crisis line support.

Increasing attention to value for money was a significant recommendation of Saskatchewan's Fyke Report; this consideration must be central in all forthcoming discussions concerning restructuring health care reform. There is evidence to suggest that a community-based healing centre costs less and promotes healing in all aspects of being– physical, mental, emotion and spiritual. It appears to be more cost effective. One recommendation that flows from this research is that core funding be made available for community-based, holistic healing centres to provide comprehensive services for those

healing from CSA.

It is the high incidence of prescribed drug use that perhaps highlights best the need for taking seriously the benefits associated with other more holistic forms of healing. Only half of the women found the health care services they received to be satisfactory. The average cost of the care the women received was $4,387 per woman per year. "Satisfactory" is not good enough considering the cost. Medical intervention typically leads to significant amounts of psychiatric medication, hospitalization, and extreme medical procedures such as surgeries. Dealing with the symptoms of CSA not only uses significant health funds, but also strains other social resources.

In 1990, Rix Rogers, Special Advisor to the Minister of Health and Welfare on Child Sexual Abuse issued Reaching for Solutions. He recommended, among other things, "that addressing the needs of adult survivors of child sexual abuse should be an important objective for provinces and territories, and that self-help and other community-based support programs for survivors be considered eligible for cost-sharing programs by the federal government." He also recommended that "the federal government fund research and evaluation studies into the effectiveness of different treatment intervention strategies for victims, families, and offenders."

In its final report, the Canadian Panel on Violence against Women reported:

> The health care system must develop an approach to women's experiences of violence that recognizes its root cause. The focus must be on long-term intervention rather than on piecemeal and short-term solutions. Medical intervention must proceed not by making decisions for women, but by enhancing their ability to analyse alternatives and find their own course of action. (p. 212)

This is not to say that the health care system should not provide services for victims of CSA but rather the need is there for other complementary/alternative services that may reduce the number of prescribed drugs, hospitalizations and medical services and at the same time provide the holistic healing the CR-survivors are calling for. After all, it

must be remembered that nine of the twelve CR-survivors in this study found the health care services dealing specifically with the impact of their CSA to be unsatisfactory, that is 75% of the CR-survivors.

Therefore it is recommended that:

7. Saskatchewan Health, establish a committee to assess the potential of selected complementary and alternative therapies for improving health outcomes and reducing health care costs in the treatment of symptoms resulting from childhood trauma, and to make appropriate recommendations concerning the inclusion of selected complementary and alternative therapies as publicly insured health services for trauma survivors. The committee should include representatives from Saskatchewan Health, Department of Social Services, and trauma survivors;

8. Saskatchewan provincial funding and budgetary commitments be provided for community-based agencies to provide comprehensive, holistic healing services to survivors of CSA;

9. Complementary/Alternative care workers be licensed under a professional act which will require adherence to a Code of Ethics.

The authors of this Report further recommend that:

10. That participatory action research continue to be funded by Health Canada; such research can make use of the substantial body of knowledge possessed by CSA survivors and could serve as the basis for designing programs of prevention, early detection, and treatment of CSA;

11. Health Canada and other funders provide funding for research into complementary and alternative medical care.

Health Care Policy Implications

The previous recommendations bring with them health care policy implications that include:

1. Medical Services Insurance be expanded to include proven complementary and alternative therapies provided by accredited service providers;
2. Complementary and alternative service providers be accredited under Provincial Legislation and bound by a Code of Ethics and other regulations;
3. Survivors of childhood sexual abuse be participants in all the health care policy planning committees;
4. Childhood violence, including sexual abuse, be incorporated as one of the determinants of health;
5. All policies and procedures affecting the health of children be reviewed to ensure they are drafted with the assumption that children are vulnerable to abuse and exploitation;
6. That the rights of children, as protected in the International Convention on the Rights of the Child, be given prominence in all governmental actions.

Suggestions for Further Research

1. An examination of the costs and efficiencies associated with the delivery of complementary and integrative health care services in a community-based healing centre on a sustained basis. A detailed line item cost analysis of both conventional and community-based complementary approaches for addressing CSA would be useful in identifying the comparative cost structures of the two systems, and would help determine how the two systems might be blended to create an integrative approach which would use the best of both systems in a cost-effective manner.

2. An exploration of the abnormally high incidence of several health-related conditions among CSA survivors. (See Appendix D for a list of health conditions

reported by the participants in this study.) Exploration would involve developing a plausible explanation of the causal pathways by which child sexual abuse leads to increased susceptibility to specific medical conditions in adult life. This possibility also raises the question of whether early detection and appropriate intervention involving deep inner psychological healing could reduce the incidence of these medical conditions.

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Appendices

Appendix A: Consent and Ethics Forms

Tamara's House:
Services for Sexual Abuse Survivors, Inc.
3310 Fairlight Drive, Suite 13
Saskatoon, SK
S7M 4Z1
Phone: (306)683-8667
Fax: (306)683-8670
Email: tamarashouse@webster.sk.ca
www.tamarashouse.sk.ca

CONSENT FORM

To participate in a research project to be undertaken by Tamara's House: Services for Sexual Abuse Survivors, Inc. and the Prairie Women's Health Center of Excellence to investigate the "Health Histories and Costs for Female Adult Survivors of Childhood Sexual abuse"

Consent to participate:

I, _____ have been informed of the nature of the above mentioned research project.

I am aware that "this project was approved by the Research Ethics Board, University of Regina." If, I, as a research subject have any questions or concerns about my rights or treatment as a subject, I may contact the Chair of the Research Ethics Board at (306)585-4775 or by e-mail: annbishop@regina.ca

I am aware the research team will include:

Team Member's Name	Address	Agency/Institution	Phone:
Sandra Burgess	13-3310 Fairlight Dr. Saskatoon S7M 4Z1	Tamara's House (Practicum student, U of R)	(306) 683-8667
Anne M. Elliott, MSW	13-3310 Fairlight Dr. Saskatoon S7M 4Z1	Tamara's House Field Project Supervisor	(306) 683-8667
Ailsa Watkinson	1121 College Drive Saskatoon S7N 0W3	University of Regina Faculty of Social Work	(306) 664-7374
Diana Decaire	1532 Central Avenue Saskatoon S7N 2H4	Tamara's House Technical Support	(306) 343-8489
Sandi Taylor	13-3310 Fairlight Dr. Saskatoon S7M 4Z1	Tamara's House Safe Worker	(306) 242-5437

I am aware my involvement as a research subject will be for the duration of the intake process, document acquisition and review, questionnaire focus group and outtake interview/focus group. I am prepared **to commit 30 hours of the project** over a **period of 4 months.**

I am aware this is a participatory action research project, therefore research subjects and research investigators will have dialogue regarding procedures and goals during the intake interview, questionnaire focus group and out-take interview.

I am aware I may **withdraw** from the project **at any time** without jeopardizing future treatment or services by the research team or Tamara's House, staff or Board.

I am aware audio or video taping will **not** be used in any part of the interview process with research subjects.

I am aware I may choose not to answer questions which make me feel uncomfortable. Also I am aware there is no right or wrong answer. I understand I may choose not to give verbal information if I so wish. I am aware if I **withdraw** from the project for any reason I may destroy my original data (medical records) by shredding or I may retain the documents in my personal possession after signing a document releasing the research team and Tamara's House of any future responsibility for my original data (medical records).

I am aware a Safe Worker will be part of the research environment for my comfort and support during the research project. She will be present during the intake interview, the questionnaire focus group and outtake focus group. She will be onsite during the rest of the data gathering process. The Safe Worker will follow the protocol for total confidentiality.

I am aware that my identity shall be kept confidential and when I agree to participate I will be assigned a coding number and a pseudonym. Further, I will obliterate all identifiers on my medical records as I receive them from their source.

I am aware a copy of my medical records will be made available to the research team after identifiers have been obliterated.

I am aware all data will be retained in a locked safe in Tamara's House for a period of 5 years and then shall be destroyed (shredded) unless I request its return and sign a document releasing Tamara's House from further responsibility for my medical records.

I am aware I will have an opportunity to review the researchers transcript of my personal data while it is being collected and recorded.

I am aware I will receive a copy of the final report upon conclusion of the project.

I am aware I will receive a copy of this consent showing my signature.

With these understandings, I agree to participate in this study.

Signature: _____

Date: _____

UNIVERSITY OF REGINA

FACULTY OF GRADUATE STUDIES AND RESEARCH MEMORANDU

DATE: April 28, 2000

TO: S. Burgess
13-3310 Fairlight Drive
Saskatoon, Saskatchewan
S7M 4Z1

FROM: T. Hadjistavropoulos, Ph.D.
Chair, Research Ethics Board

Re: Health Histories and Costs for Female Adult Survivors of Childhood Sexual Abuse

Please be advised that the University of Regina Research Ethics Board has reviewed your proposal and found it to be:

X 1. ACCEPTABLE AS SUBMITTED. Only applicants with this designation have ethical approval to proceed with their research as described in their applications. The *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans* requires the researcher to send the Chair of the REB annual reports and notice of project conclusion for research lasting more than one year (Section 1F). **ETHICAL CLEARANCE MUST BE RENEWED BY SUBMITTING A BRIEF STATUS REPORT EVERY TWELVE MONTHS. CLEARANCE WILL BE REVOKED UNLESS A SATISFACTORY STATUS REPORT IS RECEIVED.**

____ 2. ACCEPTABLE SUBJECT TO CHANGES AND PRECAUTIONS (SEE ATTACHED). **Changes must be submitted to the REB and subsequently approved prior to beginning research. Please address the concerns raised by the reviewer(s) by means of a supplementary memo to the Chair of the REB. Do not submit a new application. Once changes are deemed acceptable, approval will be granted.**

____ 3. UNACCEPTABLE AS SUBMITTED. **Please contact the Chair of the REB for advice on how the project proposal might be revised.**

T. Hadjistavropoulos, Ph.D.

c.c. G. Geller, supervisor

GM/mvs/ellrlcs2.dot

COPY

Appendix B: Demographics

Category	Number
Age of Co-researcher	
16 - 25	1
25 - 35	2
36 - 45	4
46 - 55	3
56 - 65	2
Marital Status of Co-researcher	
single	3
married	3
separated	1
divorced	3
widowed but remarried	1
partnered	1
Locality in childhood	
farm community	1
rural community	3
small urban community	5
large urban community	6
Educational Background	
elementary school	12
high school	10
secretarial school	4
university completed	3
university in progress	3

Note: Two CR's have not yet completed senior matriculation from high school. Ten CR's have post secondary training or educational backgrounds.

Appendix C: Profiles of Co-Research Survivors

JANA'S PROFILE

Chronology of Childhood Sexual Abuse

Current Age	41
Year of Birth	1960
Year CSA began	1965
Year healing journey began	1995
Year disclosed CSA to MD	1998

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 3,144.00
Emergency	$ 6.00
Hospitalization	$ 5,493.00
Prescription Medication	$ 158.00
Total Cost	**$ 8,801.00**

Total Medical Services	**Costs**	**Times Used**
BB General Practice	$ 931.43	56
HB Anaesthesia	$ 536.20	5
LB General Surgery	$ 483.00	2
PB Obstetrics and Gynaecological Surgery	$ 447.40	4
VB Pathology	$ 224.40	28
XB Diagnostic Radiology	$ 214.00	3
NB Plastic and Reconstructive Surgery	$ 200.25	3
LL General Surgery – Cardio-Thoracic	$ 70.00	1
UO Optometrists	$ 37.30	1
Total	**$ 3,143.98**	**103**

Bio-psycho-social Symptoms

Gallbladder disease, joint pain, flashbacks with bruising, dissociation, battered child syndrome, social phobia, caregiving – new baby.

Other significant healing care providers:
Adult Mental Health Services (SDH), Tamara's House.

FEVRA'S PROFILE

Chronology of Childhood Sexual Abuse

Current Age	48
Year of Birth	1953
Year CSA began	1956
Year healing journey began	1990
Year disclosed CSA to MD	

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 12,002.00
Emergency	$ 12.00
Hospitalization	$ 9,281.00
Prescription medication	$ 26,413.00
Total cost	**$ 47,702.00**

Total Medical Services	**Costs**	**Times Used**
EB Psychiatry	$ 5,251.60	142
BB General Practice	$ 2,154.79	106
CB Pediatrics	$ 1,808.75	77
XB Diagnostic Radiology	$ 736.90	16
LB General Surgery	$ 509.65	3
DB Internal Medicine	$ 360.05	6
HB Anaesthesia	$ 235.20	3
RB Urological Surgery	$ 206.30	8
UO Optometrists	$ 167.30	7
UB Chiropractors	$ 144.50	10
TB Otoloaryngolgy	$ 140.74	9
DD Internal Medicine- Gastroenterology	$ 128.50	2
FB Dermatology	$ 96.00	2
VB Pathology	$ 54.20	7
DL Internal Medicine – Cardiology	$ 7.00	1
Total	**$ 12,001.48**	**399**

Bio-psycho-social symptoms

Asthma, ear problems, colitis and irritable bowel syndrome, gallbladder removal, migraine, photophobia, rosacea, hair loss, breast lump, urological problems, dental problems, suicidal attempts, affective disorder, income maintenance. Caregiving for her children, concern for her parents who overlooked her abuse.

Other significant healing care providers:

Current psychiatrist, Nurses at Rosthern Hospital, Aboriginal Healing Lodge.

MARA'S PROFILE

Chronology of Childhood Sexual Abuse	
Current Age	35
Year of Birth	1966
Year CSA began	1972
Year healing journey began	1978
Year disclosed CSA to MD	1990

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 21,383.00
Emergency	$ 18.00
Hospitalization	$ 400.00
Prescription Medication	$ 1,597.00
Total cost	**$ 23,398.00**

Total Medical Services	**Costs**	**Times Used**
EB Psychiatry	$ 18,159.10	340
UB Chiropractors	$ 1,398.60	131
BB General Practice	$ 1,158.35	71
LB General Surgery	$ 217.00	5
FB Dermatology	$ 159.00	6
SB Opthamology	$ 129.50	4
VB Pathology	$ 97.10	10
XB Diagnostic Radiology	$ 64.10	2
Total	**$ 21,382.75**	**569**

Bio-psych-social symptoms

Asthma, major dental problems, hip problems, tight neck & shoulders, doesn't eat or sleep properly, irritable bowel syndrome (colonscopy), Post Traumatic Stress Disorder (PTSD), anxiety, depression, alcoholism, Stalked by uncle, speeding, and credit card debt, family-of-origin dysfunction.

Other significant healing care providers:

Addictions Services, Alcoholics Anonymous, Adult Mental Health Services, Psychiatrist.

APRILA'S PROFILE

Chronology of Childhood Sexual Abuse

Current Age	49
Year of Birth	1952
Year CSA began	1954
Year healing journey began	1990
Year disclosed CSA to MD	1990 (approx)

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 23,392.00
Emergency	$ 18.00
Hospitalization	$ 101,553.00
Prescription Medication	$ 13,051.00
Total cost	**$ 138,014.00**

Total Medical Services	**Cost**	**Times Used**
EB Psychiatry	$ 13,267.60	307
UB Chiropractors	$ 3,728.20	274
BB General Practice	$ 3,468.80	180
XB Diagnostic Radiology	$ 824.95	24
DB Internal Medicine	$ 322.00	4
SB Opthamology	$ 252.40	10
HB Anaesthesia	$ 228.90	8
VB Pathology	$ 225.40	33
TB Otoloaryngology	$ 212.65	7
LB General Surgery	$ 137.00	2
FB Dermatology	$ 133.15	4
DN Internal Medicine – Nephrology	$ 110.00	3
DD Internal Medicine – Gastoenterology	$ 99.00	2
DL Internal Medicine – Cardiology	$ 87.95	2
DK Internal Medicine – Neurology	$ 22.30	1
Total	**$ 23,392.20**	**873**

Bio-psycho-social symptoms

Stomach problems at birth, significant bowel and bladder problems, high cholesterol, thyroid problems, allergies, injury to neck, spine, hips (now arthritis), flashbacks with bruising, pelvic pain, nightmares, abandoned by birth mother.

Other significant healing care providers:

Tamara's House, Addictions Services, Saskatoon Family Services Bureau, current psychiatrist.

MAYA'S PROFILE

Chronology of Childhood Sexual Abuse

Current Age	61
Year of Birth	1939
Year CSA began	1943
Year healing journey began	1990
Year disclosed CSA to MD	1990 (signs not recognized by physicians)

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 7,379.00
Emergency	$ 46.00
Hospitalization	$ 12,182.00
Prescription medication	$ 938.00
Total cost	**$ 20,545.00**

Total Medical Services	**Costs**	**Times Used**
BB General Practice	$ 2,522.51	120
MB Orthopaedic Surgery	$ 1,581.75	7
XB Diagnostic Radiology	$ 1,053.05	23
UB Chiropractors	$ 1,008.45	76
HB Anaesthesia	$ 464.60	8
TB Otoloaryngology	$ 294.85	16
DB Internal Medicine	$ 261.00	5
PB Obstetrics and Gynaecology	$ 51.30	2
DL Internal Medicine – Cardiology	$ 7.95	1
Total	$ 7,377.91	264

Bio-psycho-social symptoms

Alcoholism, allergies, Irritable Bowel Syndrome (IBS), gallbladder disease, fibromyalgia, osteoarthritis, osteoporsis, hearing loss, dissociation, panic.

Other significant healing care providers:

Alanon, Alcoholics Anonymous, Professional Counseling and Mediation, Prairie Haven Counseling, Current Family Doctor, Canine companions.

JUNA'S PROFILE

Chronology of Childhood Sexual Abuse	
Current Age	40
Year of Birth	1961
Year CSA began	1967
Year healing journey began	1996
Year disclosed CSA to MD	2000

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 4,550.00
Emergency	$ 00.00
Hospitalization	$ 1,504.00
Prescription medication	$ 2,710.00
Total cost	**$ 8,764.00**

Total Medical Services	**Costs**	**Times Used**
BB General Practice	$ 4,076.60	162
UB Chiropractors	$ 206.00	20
XB Diagnostic Radiology	$ 149.00	2
VB Pathology	$ 89.20	12
UO Optometrists	$ 34.35	1
Total	**$ 4,555.15**	**197**

Bio-psycho-social symptoms
Gastro-intestinal problems, food and environment allergies, depression, prediabetic, pelvic pain, minor eating disorder, stress because needs to confront family-of-origin.

Other significant healing care providers:
Family Service Bureau, Professional counselor, Bio-energetics therapist, Tamara's House counselor, Midwives, Aroma massage therapies, Homeopath helper.

JULA'S PROFILE

Chronology of Childhood Sexual Abuse	
Current Age	25
Year of Birth	1975
Year CSA began	1988
Year healing journey began	1998
Year disclosed CSA to MD	1999

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 4,478.00
Emergency	$ 7.00
Hospitalization	$ 21,528.00
Prescription medication	$ 4,541.00
Total cost	**$ 30,554.00**

Total Medical Services	**Costs**	**Times Used**
BB General Practice	$ 1,837.56	96
MB Orthopaedic Surgery	$ 477.25	7
CG Pediatrics – Rheumatology	$ 527.20	13
CB Pediatrics	$ 476.00	15
DK Internal Medicine – Neurology	$ 397.40	8
DG Internal Medicine – Rheumatology	$ 262.03	4
DB Internal Medicine	$ 166.15	6
HB Anaesthesia	$ 128.00	2
UO Optometrists	$ 101.75	3
PB Obstetrics & Gynaecological Surgery	$ 39.50	2
UB Chiropractors	$ 32.50	2
XB Diagnostic Radiology	$ 25.35	1
DL Internal Medicine – Cardiology	$ 7.00	1
Total	**$ 4,477.69**	**160**

Bio-psycho-social symptoms
Juvenile rheumatoid arthritis, hormone problems and menstrual pain, partial complex seizures and/or flashbacks, depression, suicidal, parental lack of awareness.

Other significant healing care providers:
Adult Mental Health Services (SDH), Gynecologist.

AUGUSTA'S PROFILE

Chronology of Childhood Sexual Abuse	
Current Age	44
Year of Birth	1956
Year CSA began	1968
Year healing journey began	1999
Year disclosed CSA to MD	1999

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 2,095.00
Emergency	$ 00.00
Hospitalization	$ 00.00
Prescription medication	$ 386.00
Total cost	**$ 2,130.00**

Total Medical Services	**Costs**	**Times Used**
BB General Practice	$ 1,075.95	59
XB Diagnostic Radiology	$ 737.00	7
DL Internal Medicine – Cardiology	$ 204.30	5
VB Pathology	$ 53.90	5
DD Internal Medicine – Gastroenterology	$ 16.35	2
DB Internal Medicine	$ 7.00	1
Total	**$ 2,094.50**	**79**

Bio-psycho-social symptoms
Severe menstrual pain, breast discomfort (mammograms), heart murmur, respiratory problems, heart palpitations, anxiety, depression, neglect and isolation, enmeshed family, caregiver for elderly mother and perpetrator father.

Other significant healing care providers:
Saskatoon Sexual Assault and Information Center.

SEPTEMBRA'S PROFILE

Chronology of Childhood Sexual Abuse	
Current Age	57
Year of Birth	1944
Year CSA began	1948
Year healing journey began	2000
Year disclosed CSA to MD	1990 (approx)

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 16,345.00
Emergency	$ 64.00
Hospitalization	$ 33,697.00
Prescription medication	$ 8,128.00
Total cost	**$ 58,234.00**

Total Medical Services	**Costs**	**Times Used**
BB General Practice	$ 8,407.08	454
EB Psychiatry	$ 4,495.95	113
LB General Surgery	$ 1,601.38	23
XB Diagnostic Radiology	$ 544.95	11
HB Anaesthesia	$ 498.40	8
PB Obstetrics and Gynaecology Surgery	$ 332.90	5
DD Internal Medicine – Gastroenterology	$ 143.20	4
DK Internal Medicine – Neurology	$ 127.70	3
FB Dermatology	$ 96.00	2
UO Optometrists	$ 43.15	2
VB Pathology	$ 32.20	6
DB Internal Medicine	$ 14.95	2
DN Internal Medicine – Nephrology	$ 7.00	1
Total	**$ 16,344.86**	**634**

Bio-psycho-social symptoms
Gallbladder removed, nine miscarriages, hysterectomy, human papiloma virus, shingles, depression, attempted suicide, fibromyalgia, kidney pain in extreme, caregiver for elderly mother and perpetrator father – both deceased.

Other significant healing care providers:
Counselor, massage therapist, family doctor, psychiatrist, ER physicians.

OCTA'S PROFILE

Chronology of Childhood Sexual Abuse	
Current Age	32
Year of Birth	1969
Year CSA began	1974
Year healing journey began	1989
Year disclosed CSA to MD	has not yet disclosed

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 4,247.00
Emergency	$ 60.00
Hospitalization	$ 6,351.00
Prescription Medication	$ 702.00
Total cost	**$ 11,360.00**

Total Medical Services	**Costs**	**Times Used**
BB General Practice	$ 2,771.70	141
VB Pathology	$ 308.20	48
RB Urological Surgery	$ 267.15	9
HB Anaesthesia	$ 249.30	5
XB Diagnostic Radiology	$ 233.40	4
PB Obstetrics & Gynaecology Surgery	$ 154.50	6
UO Optometrists	$ 106.15	3
KB Neurological Surgery	$ 57.90	1
GB Medical Genetics	$ 46.00	1
CB Pediatrics	$ 39.50	2
DK Internal Medicine – Neurology	$ 13.10	1
Total	**$ 4,246.90**	**221**

Bio-psycho-social symptoms
Severe migraine, ear problems, bulge in esophagus, back problems, severe menstrual cramps, major bladder and kidney infection, ulcers (H. pylori), precancerous uterine growth, 3 pregnancies, Caregiver for her 3 children (single parent).

Other significant healing care providers:
Saskatoon Community Clinic, Emergency Walk-in Clinics, Adlerian Society, Prairie Haven Counseling, Crisis Nursery.

NOVA'S PROFILE

Chronology of Childhood Sexual Abuse	
Current Age	43
Year of Birth	1958
Year CSA began	1960
Year healing journey began	1974
Year disclosed CSA to MD	1974

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 14,611.00
Emergency	$ 194.00
Hospitalization	$ 25,990.00
Prescription medication	$ 22,868.00
Total cost	**$ 63,663.00**

Total Medical Services	**Costs**	**Times Used**
EB Psychiatry	$ 6,905.10	178
BB General Practice	$ 5,669.07	301
XB Diagnostic Radiology	$ 454.70	8
PB Obstetrics & Gynaecology Surgery	$ 354.95	9
VB Pathology	$ 307.90	36
TB Otoloaryngolgy	$ 196.35	12
HB Anaesthesia	$ 179.00	3
DK Internal Medicine – Neurology	$ 164.90	4
UB Chiropractors	$ 126.30	9
DB Internal Medicine	$ 51.55	3
DL Internal Medicine – Cardiology	$ 14.00	2
DN Internal Medicine – Nephrology	$ 7.00	1
DD Internal Medicine – Gastroenterology	$ 7.00	1
Total	**$ 14,610.62**	**574**

Bio-psycho-social symptoms
Bipolar disorder, suicidal behavior, social phobia, schizoaffective disorder, sleeping problems, high blood pressure, blackouts due to alcoholism, syphilis, human papiloma virus, gallbladder disease, ulcers irritable bowel syndrome, miscarriage, D&C's, (+5) infections of the bladder, kidney, vagina, ear, asthma, tubal libation, panic disorder, Post Traumatic Stress Disorder (PTSD), heart problems, dental problems and fibromyalgia.

Other significant healing care providers:
Tamara's House, Battleford Psychiatric Hospital, Battleford Sheltered Workshop, Alanon, Alcoholics Anonymous, Psychiatrists, Reality Therapist, Adlerian Therapist, Bioenergetics therapist.

DECA'S PROFILE

Chronology of Childhood Sexual Abuse	
Current Age	55
Year of Birth	1946
Year CSA began	very early
Year healing journey began	1990
Year disclosed CSA to MD	1990

Total Medical Care Utilization Costs:	**Summary**
Medical Services	$ 23,155.00
Emergency	$ 71.00
Hospitalization	$ 121,222.00
Prescription medication	$ 24,144.00
Total cost	**$ 168,592.00**

Total Medical Services	**Costs**	**Times Used**
EB Psychiatry	$ 10,142.50	274
UB Chiropractors	$ 3,523.45	270
BB General Practice	$ 3,239.20	145
LB General Surgery	$ 1,372.80	14
MB Orthopaedic Surgery	$ 1,292.80	11
HB Anaesthesia	$ 1,056.15	17
XB Diagnostic Radiology	$ 878.30	23
DB Internal Medicine	$ 610.25	11
VB Pathology	$ 258.80	31
DL Internal Medicine – Cardiology	$ 194.40	5
UO Optometrists	$ 173.95	8
NB Plastic & Reconstructive Surgery	$ 87.80	2
DN Internal Medicine – Nephrology	$ 82.60	1
DF Internal Medicine – Infectious Diseases	$ 82.60	1
DK Internal Medicine – Neurology	$ 80.00	1
TB Otoloaryngology	$ 79.55	5
Total	**$ 23,155.15**	**819**

Bio-psycho-social symptoms
Excess weight, hip replacement, bipolar illness, depression, suicidal, highly invasive flashbacks, Post Traumatic Stress Disorder (PTSD).

Other significant healing care providers:
Family doctor, Current psychiatrist, Primal Integration therapist, Bioenergetics therapist.

Appendix D: Cumulative List of Symptoms Presented by CR's to their Physicians

Cumulative List of Symptoms Presented by CR's to their physicians (Organized by body system)

Physical Problems

Respiratory System

- Asthma
- Lung infection
- Allergies

Cardiovascular System

- Heart problems
- High cholesterol
- Heart murmur
- High blood pressure

Nervous System

- Migraine
- Photophobia
- Shingles
- Sleep problems
- Partial complex seizures

Musculo-Skeletal System

- Joint pain
- Arthritis
- Hip problems
- Hip replacements
- Neck, shoulder and back pain
- Neck-spine injury (Battering)
- Juvenile Rheumatoid Arthritis
- Osteoarthritis
- Osteoporosis
- Fibromyalgia

Gastrointestinal System

- Gallbladder disease with surgery
- Vomiting and Diarrhea (severe)
- Colitis
- Irritable Bowel Syndrome
- Crohn's Disease
- Esophageal bulge
- Ulcers (H.pylori)

Endocrine System

- Pre diabetic
- Thyroid Imbalance
- Hormone Imbalance

Reproductive System

- Premenstrual syndrome
- Menstrual Pain (Extreme)
- Hysterectomy
- Uterine Neoplasia
- D & C's
- Tubal ligation
- Syphilis
- Human Papiloma Virus (HPV)
- Breast Pain
- Breast lump
- Miscarriages
- Pelvic pain re-occurring
- Pelvic pathology
- Pelvic inflammatory disease

Urinary Tract

- Bladder problems
- Frequent bladder infections
- Kidney infection
- Kidney pain re-occurring years after savage kicking during gang rape

Other problems

- Dental problems (severe)
- Rosacea
- Hair loss (stress)
- Eye problems
- Ear problems
- Alcoholism
- Use of street drugs occasionally

Psychiatric problems

- Social phobia
- Affective disorder
- Bipolar
- Severe depression
- Suicide behavior

Post Traumatic Stress Disorder

- Flashbacks
- Flashbacks with bruising
- Dissociation
- Multiple personalities
- Numbing of emotions
- Disordered eating
- Panic Disorder
- Anxiety Disorder

Appendix E: Types of Complementary and Alternative Medical Care

Alternative health care systems	Ayurvedic medicine Chiropractic Homeopathic medicine Native American medicine (e.g. Sweat Lodge, Medicine Wheel) Naturopathic medicine Traditional Chinese Medicine (e.g. acupuncture, Chinese herbal medicine);
Mind-Body interventions	Meditation Hypnosis Guided imagery Dance therapy Music therapy Art therapy Prayer and mental healing;
Biological based therapies	Herbal therapies Special diets (e.g. macrobiotics, extremely low-fat or high carbohydrate diets) Orthomolecular medicine (e.g. megavitimin therapy) Individual biological therapies (e.g. shark cartilage, bee pollen);
Therapeutic Massage, Body Work, and Somatic Movement Therapies	Massage Feldenkrais Alexander Method;
Energy Therapies	Qigong Reiki Therapeutic Touch;
Bioelectromagnetics	Magnet therapy;

Source: *White House Commission on Complementary and Alternative Medicine Policy*. March 2002. Chapter 2, pp. 9-10 and available at www.whccamp.hhs.gov/finalreport.html.
PAR Bibliography, United States Department of Health. p. 99.