



# **"REFRAMING RESPONSES"**

**Improving Service Provision to Women Survivors of Child Sexual Abuse who experience Mental Health Problems**

**LITERATURE REVIEW**

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**A project funded by Victims of Violent Crimes Grants Program**

**July 2006**

*Musical Lobotomy*

*If I could purge  
that part of my brain  
which stores pain*

*I would replace it  
with a gentle refrain;  
Bach, Beethoven  
or simply rain...*

*Trespasser*

*I watch  
the sliver of light  
beneath my door*

*wait  
for familiar shadows  
to cross my threshold.*

*Beneath insecure blankets  
a silent scream*

*invasion complete...*

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Many thanks to Susan Maree Jeavons.  
Permission granted for the inclusion of her poems in this document (11.10.2005).

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# “Reframing Responses”

## Literature Review

### Introduction

Over the past twenty-five years, researchers, human service providers and mental health practitioners have endeavoured to fully understand the impact of child sexual abuse on psychological health. Child sexual abuse rarely occurs in isolation but usually in the presence of other forms of abuse. Studies consistently demonstrate that adult survivors of child sexual abuse manifest high rates of mental illness, suicidality, substance abuse and poor physical health. *“There is no doubt that the physical, emotional and psychological effects accompanying sexual abuse can last a lifetime,”* (Kennedy, 2000).<sup>1</sup>

According to NSW Health, *“Women adult survivors represent the greatest percentage of women requiring services from Women’s and community health centres and mental health services.”*<sup>2</sup> In 1997- 98, child victims accounted for 34% of all presentations. Adults who experienced recent sexual assault accounted for 42% of presentations and adult survivors comprised 24% of victims seen by sexual assault services in Australia. <sup>3</sup> Comparative studies in the USA have shown similar rates of mental health service utilisation.<sup>4</sup>

Despite the statistics, service providers report that an absence of adequate resources necessitates prioritising service delivery to victims of recent sexual assault. Survivors increasingly experience ongoing barriers to access and equity since they are they do not present in ‘immediate crisis.’

The ratio of women to men adult survivors presenting to sexual assault services in 1997- 98 was approximately five to one (38% were aged between 16 - 24 years) compared to seven to one in 1993 - 94. In over 60% of cases, the time between the assault and presentation was more than ten years.<sup>5</sup>

### Terminology

Throughout the literature, many researchers and advocates have used the term ‘survivor’ rather than ‘victim’ to emphasise the inherent strength required to survive child sexual abuse, whilst others use the term ‘victim,’ reflecting the criminality of the abuse endured. The term ‘survivor’ frequently implies either those removed in time from the original trauma or further along in the recovery process (Campbell, 2001).<sup>6</sup>

Survivors frequently express their aversion to the term ‘victim’ used in any context, stressing that whilst they are survivors of child sexual abuse they remain victims of crime. Nevertheless the overriding preference amongst the women consulted was the term ‘survivor’ which has been used throughout this document to reflect their preference.

In the literature, the terms 'child sexual assault' and 'child sexual abuse' are used interchangeably. Preference varied amongst survivors consulted, but in general the term 'abuse' seemed to imply protracted abuse while 'assault' represented an event or events of shorter duration. As a result, the term 'child sexual abuse' (CSA) is used throughout this document.

To facilitate reading this review, a number of acronyms have been used. Whilst it might be perceived as offensive or dismissive to describe a person's racial, ethnic or cultural background, a diagnosed mental illness or being a survivor of child sexual abuse with an acronym, we trust that readers will appreciate the necessity to abbreviate.

Acronyms used to abbreviate organisations' names, and are identified where used. The following abbreviations are those used frequently in this paper: -

- ABS – Australian Bureau of Statistics
- ATSI - Aboriginal and Torres Straight Islanders
- BPD – Borderline Personality Disorder
- CALD – Culturally and Linguistically Diverse
- CSA – Child Sexual Abuse
- NESB – Non English Speaking Background
- NGOs – Non-Government Organisations
- PTSD – Post-traumatic Stress Disorder
- SA – Sexual Assault

## **“Reframing Responses”- The Project**

The Literature Review is a 'stand – alone' paper, but also forms part of a larger project investigating service access and equity for survivors of child sexual abuse (CSA). The literature review seeks to inform the project, which aims to highlight women's experience of the consequences of CSA, and associated risk of mental illness and comorbidity. The project has been funded through the Victims of Violent Crime Grants Program (VOVCGP).

A considerable body of evidence exists in Australia and internationally, highlighting the association between mental illness and child sexual abuse. However, whilst there are some studies investigating service delivery for victims of domestic violence and sexual assault (SA), there is little research on service delivery to survivors of CSA.

To promote service delivery that addresses the complex needs of a group of clients who habitually disappear through gaps in service provision, this project has focused on finding the most effective model to establish collaborative partnerships, between a diversity of non-government organisations (NGOs).

A growing body of literature suggests survivors' interactions with a broad spectrum of service providers (including the legal justice system) may be re-traumatising (Campbell, 2001).<sup>7</sup> This project seeks to highlight the stigmatising practices that may underpin service delivery, create or perpetuate barriers to access and equity. This is accentuated for survivors from marginalised groups, e.g. Indigenous; culturally and linguistically diverse (CALD); those with intellectual or physical disability or with mental illness and substance abuse issues.

The “**Reframing Responses**” project has undertaken a safety audit to identify gaps and barriers to service provision. An important element of the process is consumer participation. Service providers and survivors of CSA have been invited to participate in confidential interviews in order to provide qualitative material and personal experiences to the project.

Consultant to the project, Dr. Louise O’Brien, University of Western Sydney, has facilitated the qualitative study and development of a continuum for a safety plan, which will be included in a ‘Reframing Responses’ report and recommendations.

### **Scope of the study**

It has been determined that this study should particularly centre on female survivors. Although epidemiological data confirms that both genders are sexually abused, females have been shown to be substantially at higher risk. Consequently, to date, research has focused primarily on women. The paucity of information regarding males makes it difficult to assess whether these summarised findings also apply to populations of male survivors.

Whilst this project in no way seeks to ignore, marginalise or minimise the issues for male survivors of CSA, it is felt that men’s experience of abuse and the repercussions may be dissimilar to those of women, and an independent study is necessary to address and clarify men’s issues.

Those involved in the project strongly recommend a further study acknowledging this need and express their support for a project and a willingness to share knowledge and experience.

### **Prevalence of child sexual abuse in Australia**

Evidence has identified that one in three girls and one in six boys are sexually abused before the age of eighteen.<sup>8</sup> The Australian Institute of Health and Welfare (AIHW) stated that in 2004 - 05, 252,831 cases of child abuse were reported.<sup>9</sup>

In a six-month telephone survey conducted over a period during 2002 -03, data on 6,677 women who provided information about their experiences of sexual and physical violence, suggested that risk of sexual violence in adulthood is doubled for those women who have experienced CSA. Eighteen per cent of participants reported that they had been sexually abused before age sixteen.<sup>10</sup>

The NSW crime statistics for the March quarter 2005, record sexual assault figures for the year at 4,134 and other sexual offences at 5,386.<sup>11</sup> These figures fail to identify CSA as a component, merely representing incidents brought to the attention of Department of Community Services (DoCS) and the criminal justice system.

Studies from a broad spectrum of service providers highlight that these figures are a ‘drop in the ocean’ of actual assaults, because available data primarily reflects reported instances of adult sexual assault. Research suggests that sexual assault is one of the most under-reported crimes, “*hidden victims who do not report their victimisation to the police or to health officials, make them invisible in official statistics,*” (Schwartz, 1997).<sup>12</sup>

It is widely accepted that police and Australian Bureau of Statistics (ABS) data in the Women's Safety Survey (1996), the first nationwide survey into the extent of sexual assault and violence perpetrated against women, extensively under-represents sexual assault in the community, with less than 5% of reported cases resulting in a conviction.<sup>13</sup>

However, numerous studies have identified that 39% of adult sexual assault (SA) survivors have experienced other or multiple assaults. This contrasts significantly with figures from the Australian Bureau of Statistics (ABS) of 18% of incidents since the age of fifteen.<sup>14</sup>

Re-victimisation is commonly documented amongst survivors, for example: to run away from home; to be raped; to have coercive sexual experiences and to marry physically and sexually violent men (Nurcombe, 2005).<sup>15</sup>

The National Association of Services against Sexual Violence (NASASV) in a *Snapshot Data Collection by Australian Services against Sexual Violence: June 2000*,<sup>16</sup> recorded service user characteristics in fifty-one participating services over a three-week period. This represented 3,837 contacts with a diversity of providers, each service user being recorded once regardless of the number of contacts with a particular organisation. According to the report, 2,395 (62%) of service users were survivors. The largest single category numbering more than 50% represented contacts related to sexual abuse during childhood. The largest group was aged 20 -29, followed by those age 30 - 39.

There is scant evidence available on prevalence of CSA, and the information is frequently unclear due to the complex and diverse definitions used.<sup>17</sup> A study by Fergusson and Mullen (1999a) using a sample of only 100 participants found non-contact sexual abuse definitions including pornography, photography, watching and exposing had a prevalence of 8 - 62% of women, and 3 - 29% of men.

When the definition focused purely on penetration or intercourse, whether digital, vaginal or anal, the rates varied between 1.3 - 28.7% for women and 1.2 -14.1% for men. Fergusson and Mullen (1999) concluded that overall, in situations in which children had been subject to the sexual gratification of another, the prevalence rate was 1 in 3 women, and 1 in 6 men.<sup>18</sup>

A report cited in the *Comprehensive Textbook of Psychiatry* estimated that between 12 and 15 million American women had been, "subject of incestuous attention" and that up to 300,000 children are sexually abused every year (Sadock, 1989).

Other reports suggest that between 15 -19% of women had been molested as children. Russell (1986) studying 970 randomly selected non - patient women, found that 38% had been abused by an adult before age eighteen.<sup>19</sup> Whilst the Victorian Victims of Crime Survey (1998) reported that women were 10 times more likely to be victims of SA than men, men were slightly more inclined to report incidents to the police.<sup>20</sup>

It is difficult to accurately define and categorise the number of adults presenting with a history of CSA as a percentage of all survivors who access a diversity of services and whose survivor status may remain unidentified. However, the National Association of Services Against Sexual Violence (NASASV) identified that females represented over 85% of service users across all sectors.<sup>21</sup>

Sources from the USA report that a history of CSA is widespread amongst prostitutes, drug addicts and prison inmates, suggesting that the cases most likely to come to the attention of community services and the justice system come from socio-economically disadvantaged sectors of the community, and incest and abuse at more prosperous and educated levels of the community are more likely to be shrouded in secrecy.<sup>22</sup>

Whilst much evidence suggests that abuse occurs across all socioeconomic, racial and ethnic categories at the same frequency, it is hard to validate because of issues of secrecy and stigma.

## **Repressed Memory Syndrome**

The phenomenon of repressed memory represents the recovery of memories previously inaccessible to the individual. Thomson (1995) writes that, "*The inaccessibility of the memories of early trauma is explained by the concept of repressed memory. An unconscious mechanism protects the self of the individual from being overwhelmed by the memories of the traumas by quarantining those experiences from consciousness,*" (p. 97).<sup>23</sup>

Repression is a core concept of psychology. In response to trauma, the limbic system (in the centre of the brain, which regulates survival behaviour and has an intimate relationship to the (ANS) autonomic nervous system) activates the ANS to deal adaptively with a survival response.<sup>24</sup> This response relegates the event in the subconscious.

Whilst the memory remains inaccessible, survivors can manifest a multitude of mental illnesses and/or Post-Traumatic Stress Disorder (PTSD) in which the trauma repeatedly intrudes on somatic reality, long after an event or events took place.

As a consequence, and in order to 'self soothe,' (the capacity to comfort oneself) a number of survival strategies such as substance use and abuse may present as coping mechanisms.<sup>25</sup> Memories of abuse can begin to emerge into consciousness at a later date, including during presentation for treatment, counselling or community assistance. Any number of symptoms, behaviours, social and psychological distress can manifest prior to presentation.

Controversy abounds around the concept of 'repressed memory' with opponents questioning its validity, despite an abundance of claims supporting recovered memories from counsellors and therapists working with survivors.

Professionals such as Dr. R. Gardner (Psychiatrist, Harvard University), proponent of the Parental Alienation Syndrome, labelled the recall of childhood sexual abuse memories as '*fantastic*' and evidence of women's '*suggestibility*' to other people's ideas. His research was used to support the views of advocates of accused perpetrators. Coercive therapy and a deliberate conspiracy between practitioners and clients to destroy formerly happy families were also cited,<sup>26</sup> "*fabricated by disturbed and vindictive adults or overzealous therapists,*" (Williams, 1995).<sup>27</sup>

Opponents maintain that, "*there is little research support for the concept of repressed memory and that alternative explanations for allegations of childhood abuse surfacing many years later are more feasible,*" (Thompson, 1995).<sup>28</sup> Loftus (1993) writes that, "*despite the confidence with which these assertions are made, there are few studies that provide evidence of the extent to which repression occurs,*" and suggests that, "*if some clinicians were under the belief that repression of memory is common, they may have communicated this belief to their clients.*"<sup>29</sup>

Medin et al., (1992) suggest that, "*laypeople's embedded or intuitive theories about repressed memories guide society's accepted wisdom on the subject, and that such implicit theories can also shed light on how therapists' theories of repression are created, and how they might be derived from a therapist's own implicit theories.*"<sup>30</sup> Statements such as these have perpetuated the "false" memory myth underpinning ongoing attempts to discredit survivors, and influence both professionals and the public to disbelieve the recovery of childhood memories.

Opinions about the commonness of repressed memories are expressed not only by those in the therapeutic community, but also by legal scholars arguing for amendment to legislation. However, despite considerable research evidence by respected practitioners such as psychiatrist John Briere (2002)<sup>31</sup> supporting the frequency of repression, arguments abound as to the '*idiosyncratic interpretation*' of research, and the reliability of recalled memories due to absence of corroborative evidence.

Similarly, Cozolino (2002) describes reaction to trauma as predictable and connected to well understood biological processes. In the absence of a supportive context, creating the neurobiological conditions for the reestablishment of neural coherence through integration of cognition, affect, sensation and behaviours, an abused child may remain dissociated from the trauma forever.<sup>32</sup>

Traumatic amnesia and delayed memory retrieval of traumatic events has been widely documented for almost 100 years, and was scientifically accepted in the context of war, accident or disasters.<sup>33</sup> The concept only became controversial when it referred to child sexual abuse.

Extensive research on traumatic amnesia points to the significance of the victim's age at the time of the abuse and the duration of the abuse. More recent evidence suggests that amnesia is more likely to occur when the child is dependent on the abuser for survival. Traumatic amnesia may last for hours, weeks or years and recall can be triggered by sensory or affective stimuli reminiscent of the original event. This phenomenon logically occurs outside of the victim's ability to, "*consciously will a memory into existence,*" (Cossins, 1999).<sup>34</sup>

Clinical samples on the prevalence of traumatic amnesia and the later recall of memories within the general population vary. Figures in Australia and the USA range from 18% to 78%. It could be expected that these samples would include those most troubled by the repressed memory of abuse and likely to seek therapy.

The most definitive study on delayed recall was a non-clinical sample of adult survivors whose sexual histories had been documented at the time of the abuse (Williams, 1995).<sup>35</sup> Between 1973 and 1975, 206 girls aged ten months to twelve years had been examined after a report of sexual abuse. Seventeen years later, 38% of 129 of the 206 subjects (i.e. those that could be located) had not recalled the abuse when interviewed.<sup>36 37</sup>

Williams (1995) concluded that amnesia was a, “*fairly common event*,” although she acknowledged the possibility of other reasons contributing to non-disclosure, and documented the lack of certainty most of the women experience about their memories which frequently related to an inability to trust self-perceptions of reality.<sup>38</sup>

The frequency of recovered memory is well documented and the invalidation of uncertainty is no reason to conclude that memory is false or unreliable.<sup>39</sup> Freyd (1996) reported high instances of corroboration for previously amnesic clients with recovered memories of sexual abuse.<sup>40</sup>

Similarly, Whitfield and Stock (1997), in a retrospective study, surveyed 100 people who identified themselves as abused prior to age eighteen. Thirty-two per cent reported that for some period of time they had experienced total amnesia, and 36%, partial amnesia.<sup>41</sup> They concluded that abuse at a younger age was significantly associated with less recall of memory. Interestingly, only 3% of the sample reported recovery of memory during therapy. In a total of 31 studies including their own, Whitfield and Stock (1997) reported that, “*85 per cent of subjects had abuse experiences corroborated*,” (pp.99 -22).<sup>42</sup>

## **Aetiology**

### **Impact of child sexual abuse on mental health**

Numerous studies employing variously clinical convenience samples (usually of students) or random community samples, have examined the association between a history of CSA and subsequent mental illness in adult life. There is an established body of knowledge clearly linking CSA with higher rates in adults of depressive and anxiety symptoms, substance abuse disorders, eating disorders and post-traumatic stress disorders (Briere & Runtz, 1990, Winfield et al., 1990; Bushnell et al., 1992; Mullen et al., 1993; Romans et al., 1995, 1997; Fergusson et al., 1996; Silverman et al., 1996; Fleming et al., in press). A more controversial study links multiple personality disorder with CSA (Bucky & Dallenberg, 1992, Spanos, 1996).<sup>43</sup>

The precise psychological impact of CSA differs as a result of a number of variables. This may include one or more variables, such as: disposition; bio-psychological factors; family environment, security; positive parent/child attachment, and previous history of support or abuse. In addition, it appears that a specific type of child abuse is, to some extent, related to the form of subsequent psychological distress or disorder.<sup>44</sup>

Abusive behaviours and assault, whether physical, sexual or psychological can create long-term interpersonal difficulties, distorted thinking patterns and emotional distress. Extensive research suggests that amongst the variety of negative mental health effects of CSA is Post Traumatic Stress Disorder (PTSD), a view supported by CSA workers.<sup>45</sup>

Puttman (1997) posits that a child experiencing abuse develop strategies, which become coping mechanisms enabling functioning, and yet detach from the emotional and physical pain of events, especially when abuse continues over a protracted period.<sup>46</sup>

A child may develop a, “*style of relating whereby she psychologically attenuates or avoids certain attachment interactions with a given abusive caretaker,*” (Bowlby, 1988).<sup>47</sup> Whilst such defences are used to protect the child from overwhelming anguish and distorted environmental input, they also tend to reduce access to positive attachment stimuli that may be present.<sup>48</sup>

Deprived of natural attachment - related learning and development, avoidance may become a primary response style. Difficulties associated with abuse - related attachment may be mirrored in relationships throughout a survivor’s life. “*Abusive acts thereby serve as etiologic reservoir for the development of later psychological disorder,*” (Briere, 2002).<sup>49</sup> Responses can be a direct consequence of the psychological injury sustained or as coping mechanisms as a result of the emotional distress experienced.

Based on clinical experience and research evidence a number of abuse-related symptoms have been identified as affecting psychological functioning. Briere (1992) suggests that this is broadly but not exclusively covered by the following six areas:

*“(1) Negative preverbal assumptions and relational schemata; (2) conditioned emotional responses to abuse-related stimuli; (3) implicit/sensory memories of abuse; (4) narrative/autobiographical memories of maltreatment; (5) suppressed or “deep” cognitive structures involving abuse-related material, and (6) inadequately-developed affect regulation skills.”*<sup>50</sup>

The negative core schema that a survivor adopts fundamentally affects their capacity to establish and sustain significant attachments throughout life. Survivors often experience conflictual relationships and chaotic lifestyles, frequently report difficulties forming adult intimate attachments and display behaviours that threaten and disrupt close relationships (Collins & Read, 1990).<sup>51</sup>

Pearlman and Saakvitne (1995) propose that traumatic abuse in childhood can produce more general relational disturbance, *“leading to chronic, negative expectations and perceptions around safety, trust, esteem, intimacy and control,”* which is easily activated by interpersonal interaction in the present environment.<sup>52</sup>

### **Incest and childhood sexual abuse**

The Women’s Incest Survivors Network describe the characteristics of CSA as, *“a fundamental betrayal of trust, the entrenchment of fear, shame, confusion and powerlessness... and the child’s inadequate physical and emotional resources to deal with such characteristics, severely threaten the child’s development,”* (1996).<sup>53</sup>

Whilst few empirical studies of the consequences of CSA were located, a number of eminent authors have described the processes involved. Abused children appear to exist in a constant state of autonomic arousal described as, *“frozen watchfulness,”* whilst avoiding display of inner agitation (Herman, 2001).<sup>54</sup> When avoidance fails, children frequently attempt to satisfy the abuser by demonstrations of obedience. *“The arbitrary enforcement of rules, combined with the constant fear of death or serious harm, produces paradoxical results,”* (Herman, 2001).<sup>55</sup>

Convinced of their powerlessness and the futility of resistance, many children develop a belief in the perpetrator’s absolute, almost supernatural powers over them. This may motivate a child to prove loyalty and compliance, and a redoubling of efforts in an attempt to gain control in the only way possible, *‘trying to be good.’*<sup>56</sup> Herman (2001) writes, *“The perpetuation of violence, threats, capricious enforcement of rules instil the terror and development of automatic obedience, isolation and secrecy, and fear of betrayal can destroy the relationships that would otherwise offer protection,* (p. 101).<sup>57</sup>

Abused children habitually suffer social isolation, a situation frequently enforced by the perpetrator in order to preserve secrecy. The child may not only perceive that the perpetrator is dangerous, but other responsible adults are complicit and failing to protect her. Abandoned to her fate, victims frequently feel abandonment more acutely than the abuse itself, particularly if other adult carers were disarmed by intimidation and failed to intervene.<sup>58</sup> Faced with profoundly chaotic relationships the abused child experiences overwhelming developmental challenges.

A way to develop attachment, trust and safety with those who are untrustworthy or unsafe, and develop a sense of self and a capacity for self-regulation in an environment where the body is at the mercy of others must be found. *“She must find a way to preserve hope and meaning.”* Ultimately as, *“an adult she must develop a capacity for intimacy from a childhood that defined her as a slave to another’s sexual demands, where relationships were corrupt,”* (Herman, 2001).<sup>59</sup>

To maintain hope and meaning, a child will often preserve faith in her parents or caregivers, constructing explanations absolving them from blame and responsibility. The array of psychological adaptations adopted are defence mechanisms to accommodate primary attachment to her parents.

To this end, memory of the abuse is suppressed from awareness or rationalised, minimised or excused. In order to escape the unbearable reality, the child may alter events in her mind by using a plethora of dissociative responses. Studies have documented the close connection between the severity of CSA and the degree to which survivors experience dissociative states (Herman et al, 1989, Sanders et al., 1989, Chu et al., 1990, Sanders et al., 1991).<sup>60</sup>

Whilst not all abused children develop an ability to dissociate, even those that do, cannot always rely on it for protection. When avoiding reality becomes impossible, children will construct a rationale to justify the abuse. A belief in their inherent 'badness' is usually seized upon. If, "*she is bad and can become good*", then there is some meaning and hope for the future. "*She has the power to change events, and earn the forgiveness, protection and love she seeks,*" (Herman, 2001).<sup>61</sup>

Normal thought patterns of self-blame and loss of self-esteem, common to early childhood are congruent with thought processes of traumatised people of all ages. The propensity towards self-blame and lack of worth are reinforced by persistent childhood abuse, where neither time nor corrective experience can alter this perception.

Frequently, feelings of rage and aggressive behaviour, which are normal reactions to abuse, become manifest during childhood. These feelings may be expressed in adulthood by an inability to resolve conflict (a sense of being under constant attack coupled with an inability to modulate anger), endorsing a sense of inner badness.

Unable to develop a sense of safety, abused children frequently seek external sources of comfort and solace. This paradox can be observed in abused children who desperately and indiscriminately seek the affections of others, often from the very parents or individuals who are their abusers. This fragmentation becomes central to personality organisation, preventing integration of knowledge, memory, emotional states and bodily experience. It is not uncommon for survivors to repeat this pattern into adulthood relationships with abusive partners.<sup>62</sup>

## **Psychological consequences of child sexual abuse**

### **Depression**

CSA often fosters the conditions for the development of mental illness, particularly depression and anxiety disorders. The most frequent symptom of survivors of CSA is depression. Adult survivors are 3 -5 times more likely than non-victims to experience a major depressive episode at some time during their life.

Survivors of CSA, different to other female depressives, exhibit early onset and a tendency towards chronicity. Lowered self-esteem and a sense of hopelessness are frequently found in women who lack an intimate and confiding relationship, typical amongst CSA survivors (Henderson & Brown, 1988; Harris, 1988; Romans et al., 1992).<sup>63</sup>

## Dissociation

Dissociation is usually triggered by a strong emotional reaction such as feelings of terror, surprise, shame, helplessness, or feeling trapped or exposed.<sup>64</sup> *“Dissociation is an unconsciously determined ego defence involving a disruption in the normal interconnection between memory, emotion, and self-awareness,”* (Nurcombe, 2005).<sup>65</sup> This can present as: vagueness; excessive daydreaming; de-personalisation; de-realisation; disengagement from the immediate environment; altered body perception; emotional numbing; amnesia for traumatic experiences; and at the extreme end of the spectrum can manifest as Dissociative Identity Disorder (DID).

Dissociative symptoms have been found in adults with a history of CSA.<sup>66</sup> Several studies established that 60 -83% of patients with DID (previously classified as multiple personality disorder) have a history of sexual abuse, and in many cases, physical abuse as well.<sup>67</sup> Beitchman et al., (1992) question the reliability of a diagnosis of dissociative disorder and emphasise the frequent contamination of sexual abuse by physical abuse which, *“throw some doubt upon the specificity of the link between CSA and dissociative disorder,”* (p.109).<sup>68</sup>

## Post Traumatic Stress Disorder (PTSD)

Data from a large-scale study in the USA comparing the effects of different types of traumatic events (whether one episode or prolonged trauma) suggest that the experience of a CSA and SA (male and female) may be more likely to lead to Post Traumatic Stress (PTS) and PTSD than other types of traumatic events. This percentage was significantly higher at 54% than the 38.8% diagnosed in men who have experienced combat (Kessler et al., 1995).<sup>69</sup>

Children victimised by psychological, physical and sexual abuse have been shown to, *“have significantly greater probability of demonstrating brainwave abnormalities in the left frontal and temporal regions,”* (Ito et al., 1993).<sup>70</sup> Brainwave dyscoherence may put individuals at greater risk of psychiatric disorders such as PTSD.

Unresolved trauma often results in ‘information-processing’ deficits that disrupt integrated neural processing. A lack of right and left hemisphere functioning, subsequent to the experience of traumatic stress, is frequently predictive of later development of PTSD, and the disruption of interpersonal bonding and bodily regulation processes (Henry et al., 1984).<sup>71</sup>

Symptoms of PTSD include re-experiencing the trauma without the trauma being present, avoidance of situations associated with the trauma, emotional numbing and hyper-arousal. Perhaps the most dramatic trauma-related symptom is dissociation, which can involve phenomena ranging from altered awareness to flashbacks and out of body experiences.

An increased likelihood of PTSD symptoms observed in a medical setting with certain types of procedures such as pelvic examinations, colonoscopies, endoscopies, gastrointestinal exams, and gynaecological examinations, which insert an instrument into a bodily orifice, may be sufficiently reminiscent of sexual trauma to provoke a post-traumatic reaction in patients who have experienced sexual trauma.<sup>72</sup>

Invasive procedures are the most dramatic examples of 'trigger' events occurring in a medical setting. Even in a typically non-threatening environment, a number of other triggers may evoke traumatic responses including: being touched; the power differential between patient and medical practitioner; the removal or absence of clothing and the focus on bodily pain (Robohm & Buttenheim, 1996).<sup>73</sup>

In a study by Robohm and Buttenheim (1996), a large percentage of sexual trauma survivors reported having "*unpleasant*" experiences during gynaecological examinations. These included overwhelming emotions, unwanted or intrusive thoughts, traumatic memories, sensory recall, and feelings of detachment from the body. Many survivors did not report these experiences to medical practitioners.<sup>74</sup>

In this same study, both women who had and women who had not experienced childhood sexual trauma reported that they experienced anxiety during pelvic examinations. However, women who had been sexually traumatised reported that having their sexual organs examined was the primary reason for discomfort, whereas women who had not been sexually traumatised reported that physical discomfort was their most common reason for discomfort.

Advocates for Survivors of Child Abuse (ASCA) identify dental procedures as a trigger for memories of oral rape.<sup>75</sup> Survivors anticipating such reactions may avoid required medical interventions further increasing risk to physical health.

### **Complex PTSD (CPTSD)**

Clinicians and researchers have suggested that a diagnosis of PTSD does not reflect the severe psychological harm that occurs as a result of the protracted, repeated trauma frequently experienced by survivors of CSA (Cozolino, 2002). While PTSD accurately describes the symptoms of time-limited duration, chronic trauma can continue for months or years. It can alter the victim's concept of 'self' and affect how they adapt to stressful events. Herman (2001) suggests a new diagnosis, Complex PTSD (CPTSD) to describe the symptoms of long term trauma, particularly applicable to survivors of CSA.<sup>76</sup>

### **Borderline Personality Disorder (BPD)**

Borderline personality disorder (BPD) is the name given to one of a group of psychiatric conditions called 'personality disorders'. BPD is characterised by distressing emotional states, difficulty in relating to other people and self-harming behaviour. Some researchers have estimated that up to 75% of individuals with BPD have experienced some degree of sexual abuse in childhood (Linehan, 1993).<sup>77</sup>

The causal relationship between BPD and CSA is hypothetical, and subject to reservations concerning the reliability of a BPD diagnosis and the frequent co-occurrence of: CSA; neglect; physical abuse; emotional abuse and exposure to domestic chaos in families of those diagnosed (Nurcombe, 2005; Barnard et al., 1985).<sup>78 79</sup>

Cozolino (2005) suggests that BPD may be one variant of complex PTSD, citing widespread evidence of early abuse, trauma and the presence of dissociative symptoms. Individuals with this diagnosis are characterised by, *“hypersensitivity to real or imagined abandonment; disturbances in self-identity; intense or unstable relationships; alternating idealization or devaluation of themselves or others; compulsive, risky and sometimes self-damaging behaviours,”* (p.31).<sup>80</sup>

Alexander (1992) suggests that the impact of CSA be understood to be a distortion of a child's working model of attachment.<sup>81</sup> Sexually abused children are often rejected, causing avoidant attachment. Parents' lack of attention to the child's needs resulting in the denial of abuse-related feelings. Sexual abuse itself affects attachment and resistant attachment, which can lead to an approach-avoidance conflict in adult relationships, predisposing the individual to a borderline personality.<sup>82</sup>

Contemporary attachment theory is based on theoretical and clinical work of John Bowlby (1969:1997). His theoretical work was adopted and expanded on by the developmental psychologist Mary Ainsworth (1978) in her investigations of mother/ child relationships and interactions. Since then, there has been a rapid growth in research, using the ideas of attachment theory as a framework for understanding how human interpersonal relationships develop and function.<sup>83</sup>

In a sample of neglected, physically abused, and sexually abused 8 -12 year old children with *“confused”* patterns of relatedness (consistent with atypical *“disorganised-disoriented”* attachment), Toth and Cicchetti (1996) found very high levels of depressive symptomatology.<sup>84</sup> It is likely that disturbed attachment accounts, in part, for the traumagenic dynamics postulated by Finkelhor (1987) as discussed in this document (p. 39).<sup>85</sup>

## **Alcohol and substance abuse**

Several studies connect CSA with alcohol and substance abuse in adolescents and adults. Briere and Runz (1990)<sup>86</sup> found that compared to non-abused female clients, sexually abused females in crisis centres were four times more likely to have a history of substance abuse and twice as likely to be alcoholic (Nurcombe, 2005).<sup>87</sup> Clients with substance abuse problems report high levels of exposure to CSA. This has led to extensive research into the relationship between CSA and alcohol. A review of 12 studies conducted prior to 1995 show the rates of CSA among those in treatment for alcohol abuse varied from 84% to 20% (Fleming et al., in press).<sup>88</sup>

Pribor and Dinwiddie (1992) and Swett and Halpert (1994) generally found higher rates of alcohol abuse in women who were receiving treatment for mental health problems with a history of CSA.<sup>89</sup> However, conflicting results on the possible relationship between CSA and alcohol abuse have also been reported creating doubt about the strength of an association, the causality of connection, and how any connection is mediated and influenced by other factors.

For instance, Fleming et al., (in press) in a case-control study using a sample of 710 Australian women proposed that, *“a history of child sexual abuse was not, by itself, sufficient to cause alcohol dependency in women. The relationship between child sexual abuse and alcohol abuse more likely reflects a complex interplay between child sexual abuse and a range of other factors in a woman's life.”*<sup>90</sup>

The study emphasised that the combination of a perception of a mother perceived as being neglectful and/or controlling, and being sexually abused did increase the risk of alcohol abuse. Evidence exists of the protective effects of a caring, supportive mother, which may limit some of the potentially adverse effects of CSA on subsequent susceptibility to alcohol abuse.<sup>91</sup>

Fergusson and Mullen (1998) examined the interactions between the severity of abuse, family relationships, survivors' preconceptions about alcohol reducing sexual anxieties and finally, drinking habits of their eventual partner. They identified a complexity of dynamic interactions between development, abuse, family and social experiences, and the emergence of problems in adulthood.<sup>92</sup>

In a study of pathways *between* drugs and crime, drug abuse consistently pointed to histories of sexual, physical and/or emotional abuse. *"Eighty-seven per cent of incarcerated women were victims of sexual, physical or emotional abuse in either childhood (63 %) or adulthood (78 %). The majority were victims of multiple forms of abuse; childhood and adult abuse were correlated with drug dependency and involvement in the sex trade."* (Johnson, 2004: xiv).<sup>93</sup>

### **Suicidality, self-mutilation and damaging lifestyles**

Suicidality has been associated with CSA in a number of studies,<sup>94</sup> though not in all (Sedney & Brooks, 1984).<sup>95</sup> In one community study, 16% of survivors had attempted suicide compared to 6% of their non-abused cohorts.<sup>96</sup>

Self-mutilation is consistently described among survivors (Lindberg et al., 1995).<sup>97</sup> In one study, 70% of survivors with a history of CSA who suffered from anorexia or bulimia had self-harmed by overdosing, poisoning, cutting or burning themselves or by head-banging.<sup>98</sup>

Indiscriminate sexual behaviour and sexual promiscuity have also been described as one of the consequences of CSA,<sup>99</sup> as is an increased risk of unintended pregnancy and sexually transmitted disease.<sup>100 101</sup>

Browne and Finkelhor (1986) identify prostitution as sequelae to CSA and refer to existing research as finding a 46% prevalence of CSA among a sample of prostitutes (whilst not matching them against a comparison group of non-prostitutes).<sup>102</sup>

CSA has also been associated with running away from home in adolescence and female adolescent delinquency, both of which can be linked to prostitution.<sup>103</sup> Extensive research suggests that many adult and adolescent prostitutes are reported to relate their choice of profession to childhood abuse (Bagley & Young, 1987).<sup>104</sup>

Easteal (1994) found that 80 - 85% of women in Australian gaols have been victims of incest or other forms of abuse.<sup>105</sup> In a study of 27 NSW correctional centres, Butler et al. (1999) found 65% of male and female inmates were victims of child sexual abuse and physical assault.<sup>106</sup>

## Eating and anxiety disorders

Eating disorders, particularly bingeing and purging, have been linked to CSA and PTSD. This hypothesis requires further support.<sup>107</sup> Individual risk factors for eating disorders include: female sex; genetic vulnerability; family history of psychiatric disorder; pre-morbid obesity; a perfectionist or somewhat obsessive personality style; dysfunctional family and social systems; obsessive-compulsive disorder; prior depressive disorders; BPD (poor sense of identity, mood instability and a tendency to engage in impulsive self-harming or risk-taking behaviour, such as wrist slashing, substance abuse and promiscuity) and a previous history of sexual abuse.<sup>108</sup>

Much research has focused on bulimic women (with or without PTSD) who experienced childhood sexual trauma. However, Lederman (2004) writes, *"It is clear that women who have PTSD from any type of trauma (for example, aggravated assault, emotional abuse or bereavement) have a higher risk for bulimia. PTSD is the risk factor for developing Bulimia Nervosa, not childhood sexual trauma."*<sup>109</sup>

It is unclear whether the eating disorder results from the heightened level of anxiety associated with PTSD, but according to Timothy Brewerton, MD of the Medical University of South Carolina, one of the principal researchers in the National Women's Study, *"purging as opposed to bingeing, seems to be the key behavior linked to PTSD,"* (2004). According to Dr Brewerton, the act of purging has a numbing effect and many bulimics report that they feel more relaxed and less anxious after purging.<sup>110</sup>

## Impact of child sexual abuse on physical health

The Illinois Coalition Against Sexual Assault (CASA),<sup>111</sup> reporting on the long term consequences of CSA, referred to a study by Golding (1994) into the physical health consequences of CSA on a large random cohort in Los Angeles. They found that 29.3% of women with a sexual abuse history reported at least six somatic symptoms compared to 15.8% of other women.<sup>112</sup>

Gastrointestinal (GI) problems may be second only to depression as the most frequent long term consequence of CSA. As many as 71% of female adults and adolescents who experience sexual abuse for more than two years, may later develop GI disorders.<sup>113</sup> Another common complaint is irritable bowel syndrome, as is chronic abdominal pain. Almost one third of women with these conditions have been victims of childhood rape or incest (Drossman, 1995).<sup>114</sup>

Citing a study by Springs and Friedrich, Forrest (1994) found that CSA survivors are two and a half times more likely to experience: pelvic pain or pelvic inflammatory disorder; breast diseases ranging from fibrocystic changes to cancer; yeast infections and one and a half times more likely to have bladder infections. They also found that survivors were more likely to have complications during pregnancy and chronic pain including backaches and headaches. It was evident that the more serious and prolonged the abuse, the more chronic the resulting medical problems.<sup>115</sup>

## Other consequences of child sexual abuse

### Sexual problems

Adults abused as children often report sexual frigidity, dissatisfaction with sex, and difficulty sustaining intimate personal relationships, (Gold, 1986).<sup>116</sup>

In a Los Angeles epidemiological study, Stein et al. (1994)<sup>117</sup> found that 20% of women reporting CSA had symptoms of sexual dissatisfaction in the previous six months, and that 36% feared sex or had experienced diminished pleasure at some time during their life.<sup>118</sup> As no control data was provided and the prevalence of sexual problems in the general population is high, no conclusion can be drawn.<sup>119</sup>

### Difficulties in pregnancy, birthing and mothering

In, *'Somebody wants to hear: the effects of child sexual assault on women's experiences of pregnancy, birth and mothering,'* Stojadmovic (2003) highlighted the physical and emotional vulnerability of any woman during childbirth which, for women with a history of CSA, may become traumatic.<sup>120</sup>

Kitzinger (1997) emphasised the concerns of potential mothers with a history of childhood abuse about dangers that their children may face.<sup>121</sup> These anxieties may alter relationships with partners and friends as women attempt to protect their children. Prescott (2002) reported that some women fear abusing their children, although research identifies this to be unlikely.<sup>122</sup> Research conducted by Finklehor (1986) and the ABS (1996) estimated that 97- 98% of sex offenders are men.<sup>123 124</sup>

Some women also report distress during breastfeeding, with bodily contact and the sensations of breastfeeding evoking memories of sexual abuse (Prescott, 2002).<sup>125</sup> These feelings may result in emotional distancing from the infant, intense feelings of guilt, self-blame and a sense of powerlessness.

Another significant theme identified in consultations with survivors about mothering and protectiveness was the use by health professionals of the term 'overprotective' to describe survivors' concerns about the safety of their children. Stojadmovic (2003) suggests that the pathologising implications of the term 'overprotective,' frequently result in 'mother blame.'<sup>126</sup> It should be understood that survivors are more alert to opportunities for abuse and therefore have a heightened sense of safety and awareness for their children.

### Adult and Youth Homelessness

On Census Night (2001), 99,900 people were homeless of whom 14% were 'sleeping rough.' Almost 50% of the homeless population were less than 25 years of age, and 26% were aged 12 -18 years. Overall, females represented 42% of the total. Of the total figure, 42.2% were in NSW.<sup>127</sup> Whilst 2% of the population identified as Indigenous, 9% of the homeless were Indigenous, 19% were 'sleeping rough,' and clearly over represented in the homeless population.<sup>128 129</sup>

Youth homelessness in Australia has doubled since 1991. An estimated 37,000 young people aged 12 - 24 are believed to be homeless at any one time, whilst approximately 100,000 young people aged 12 -24 experience homelessness every year, of which around 20% are chronically homeless. It is estimated that 90% of young people who become homeless have their first experience of homelessness when they are aged 15 or younger.<sup>130</sup>

Chamberlain and MacKenzie (2003) suggest that homelessness is, “*best understood as a process, or series of biographical transitions.*”<sup>131</sup> Whilst causality is diverse and complex, particularly relevant is the transition of youth to adult homelessness and the aetiology amongst young homeless females, which may result in a progression to chronicity.<sup>132</sup> The National Homelessness Strategy (2000)<sup>133</sup> identified several factors, which have altered the character of homelessness in recent years, several of which closely relate to CSA, sexual and physical abuse, mental illness and substance abuse.<sup>134</sup>

Extensive research studies identify ‘cause and effect’ – the close relationship between CSA and the continuation of young people remaining homeless. Speaking at a National Congress on Homelessness (2003), David Tully of Adelaide Central Mission referred to abuse as the primary factor causing young people to seek safety by leaving home.<sup>135</sup> Even when the abuse has not occurred in the family home or by a close family member, it still may remain a factor.

Having become homeless, young people are at further risk of abuse. The ‘*Living Rough Report*’ (1999) identified that during a 12 - month period 52% of homeless youth had been sexually assaulted.<sup>136</sup> The Salvation Army report, ‘*No Place that's Home,*’ stated that 45% of homeless young people reported sexual or physical abuse as a major factor in leaving home (Smith, 1995).<sup>137</sup> Likewise, a 1992 survey conducted by Macquarie University of Sydney homeless children, revealed very high levels of physical and sexual abuse, particularly of young females. Of the girls interviewed, 73% reported physical abuse and 82% had been sexually abused. The abuse mostly occurred under the age of 11(67%), with 26% experiencing the first sexual abuse between ages of 12 and15 years.<sup>138</sup>

Tully (2003) suggests that, “*despite the extent of the issue and implications for service delivery many homeless youth service providers are extremely reluctant to raise the issue of sexual abuse.*”<sup>139</sup> A culture of silence minimises the impact of CSA and reduces the likelihood that young people will link with appropriate services.

Isolated and dealing with the impact of childhood trauma alone, young people experience a complexity of problems exacerbated by homelessness. Once trapped into chronic homelessness, whether in unsafe accommodation or out on the streets, young people may become involved in sex work and subject to further trauma and assault. Dire consequences continue to impact daily, increasing the risk that these individuals as adults and parents will experience chronic mental and physical health problems.<sup>140</sup>

## Women with disabilities

In 2004, during the conference, *'Home Truths: Stop Sexual Assault and Domestic Violence – A National Challenge,'* Sue Salthouse from Women With Disabilities Australia (WWDA) identified women with disabilities as one of the most '*marginalised*' groups experiencing discrimination. Salthouse referred to international studies (highlighting the paucity of research in Australia) indicating that 90% of women with intellectual disabilities have been sexually abused, mostly before the age of eighteen.<sup>141</sup>

Keel et al. (2005) notes, that not only are, "*issues for women with disabilities largely excluded from most generic policies by the limits of an 'able-ist' perspective, but women with disabilities are largely invisible in both the disability and women's movements. Therefore, while the separate concerns of the disability and women's movements are indeed in danger of being diminished by "mainstreaming" of services, the concerns of women with disabilities are in danger of being ignored altogether.*"<sup>142</sup>

The Disability Discrimination Legal Association in their report, *'Beyond Belief, Beyond Justice: The difficulties for victim/survivors with disabilities when reporting sexual abuse and seeking justice,'* (2003) identified barriers for victim/survivors with a cognitive impairment as systematically operating against a criminal justice response. It would not be unreasonable to speculate that similar barriers exist for these women in accessing other services.<sup>143</sup>

## Women from culturally and linguistically diverse backgrounds (CALD)

CALD women frequently face additional barriers to accessing services. However, studies on the prevalence of violence against these women are scarce. An International Violence Against Women (IVAW) survey indicated that CALD women, "*report lower levels of physical violence than women from English-speaking backgrounds,*" but that, "*a similar proportion from both groups experienced sexual violence during the 12 months preceding the survey,*" (Keel et al., 2005).<sup>144</sup>

Research has identified factors that not only influence CALD (also referred to as (NESB) non-English speaking backgrounds) women's perceptions of what constitutes violent behaviour, but also reluctance to report (Ouzos & MacKay, (2004).<sup>145</sup> Lenore (2003) suggests, "*reasons that women from NESB backgrounds are unlikely to report are varied and include personal, cultural and religious, informational and language and/or institutional and structural.*"<sup>146</sup>

Such factors are also likely to impact on access to support services, particularly in rural areas. Services experience ongoing difficulties in engaging bilingual workers who understand the CSA-related issues. "*The difficulties for women from NESB backgrounds in accessing appropriate and adequately resourced services have remained almost unchanged over the past decade,*" (Keel et al., 2005).<sup>147</sup>

## Indigenous women

The context in which Indigenous children experience abuse is complex. Historical factors relating to colonisation, enforced institutionalisation, the removal of children and adults from family, culture and land, and the abuse by people in positions of authority all contribute to the increased risk of complex mental health disorders and co-morbidity in Indigenous survivors of CSA. Other considerations are the disabling factors of generational social disadvantage.<sup>148</sup>

Studies on the prevalence of CSA in Indigenous communities (particularly in rural and remote regions) are virtually non-existent. However, the presence of considerable anecdotal evidence should not be dismissed as it reflects people's knowledge of the communities in which they live and work.<sup>149</sup>

Shame plays a major role in the failure to disclose CSA. Disgrace, dishonour, humiliation and powerlessness for victims, extended family, community loyalty, and abuse of power by authority figures in small communities has led to significant under-reporting of CSA. However, according to Greer (1992), educator and consultant on domestic violence and sexual assault, 70 - 80% of young girls involved in the criminal justice system are victims of sexual abuse and 50% victims of incest.<sup>150</sup>

Dudgeon, Grogan et al. (1993)<sup>151</sup> and Garvey (2000)<sup>152</sup> report that despite research studies Internationally and in Australia, Indigenous people do not access mental health services at a level commensurate with need (Australian Institute of Health and Welfare, 2002:2003).<sup>153</sup>

Indigenous people in contact with mental health services are more likely to receive services, which are reactive in nature (Atkinson & Clarke, 1997, Mammoth, Stacy, Chambers & Keys, 2000).<sup>154</sup> Contributing to this problem is the inequity of access to mental health services by Indigenous people, with almost no appropriate services available for adult survivors of CSA, particularly in rural, regional and remote areas.

Few published examples of effective programs or therapeutic interventions have been located for this document. However, Waterman (2004) writes that examples of good practice exist but this information is not broadly shared, limiting opportunities for empirical and cultural validation or replication across different contexts.<sup>155</sup> This has affected service delivery at the individual level as well as more broadly at a systems level.

Whilst practitioners frequently have the desire to be 'culturally appropriate', they are frustrated by the lack of empirically grounded conceptual frameworks with proven efficacy. *"Successful outcome is mostly measured subjectively and in the absence of a consistent theoretical framework which can be applied to specific presenting issues,"* (Waterman, 2004).<sup>156</sup> Identifying successful outcomes attributable to intervention is problematic.

At a systems level, services struggle with embedding/incorporating culturally appropriate practice within policy and procedural frameworks. Models of service delivery have been traditionally mono-cultural. The integration of specific cultural and clinical competencies within system and practitioner levels is required to increase access to mental health services by Indigenous women (National Aboriginal and Torres Strait Islander Health Council, 2003).<sup>157</sup>

The components of cultural competence have been defined under a number of different counselling competencies: cultural awareness and beliefs, cultural knowledge and flexibility (Cross, Baron, Dennis & Isaacs, 1989).<sup>158</sup> Practitioners need to be able to identify, intervene and treat mental health problems in ways that recognise the central role that culture plays in mental illness (Cross, 1995).<sup>159</sup>

Lack of service provision aside, engagement of Indigenous women in mental health services has traditionally been problematic. Not only are Indigenous people less likely to engage in mental health services but are likely to engage chronically and for shorter periods of time (McKendrick & Thorpe, 1994, Vicary, 2002).<sup>160</sup> The primary explanation for this seems to be the 'cultural inappropriateness' of existing services, or the failure of mental health services and clinicians to embrace Indigenous conceptualisations of health and wellbeing (Dudgeon, 2000; Garvey, 2000).<sup>161</sup>

However, few attempts have been made to define or fully operationalise the basis of cultural inappropriateness, or provide methods by which clinicians might adapt their practice. McLennan and Khavarpour (2004) suggest that, consulting and collaborating with individuals and their communities as to how their needs may be met is essential in establishing culturally appropriate initiatives.<sup>162</sup>

## **Lesbian women, child sexual abuse and health inequalities**

In 1999, Roberts and Sorenson published a survey of 418 women in Chicago and concluded that lesbians are more likely to have been sexually abused as children. They also found that lesbians were less likely to abuse alcohol than heterosexual women, but more likely to have attempted suicide. Domestic violence rates were about the same.<sup>163</sup> Twice as many lesbians reported sexual abuse before the age of fifteen, compared to heterosexual women. Of all the lesbians surveyed, 29% reported such abuse, more black lesbians than white lesbians said they were victims.

Forty-eight per cent of lesbians, and 45% of heterosexual women, said they had contemplated suicide, but only 8% of the latter had actually made a suicide attempt, as compared to 18% of the lesbians surveyed.<sup>164</sup>

The development of 'cultural competence' to facilitate the disclosure of sexual orientation has been emphasised in numerous studies, as is the need to promote policies that address the specific needs of sexual minorities with regard particularly to survivors of CSA.<sup>165</sup>

## Dual victimisation and misdiagnosis

Women with a history of CSA often experience abusive adult relationships (Nurcombe, 2005).<sup>166</sup> Rosewater (1988) explored how women experiencing domestic violence responded on a common diagnostic tool for psychiatric illness, the Minnesota Multiphasic Personality Inventory (MMPI). She described how, *'battered women'* could be misdiagnosed, *"with what was termed 'masochistic personality disorder' and later 'self-defeating personality disorder,'"* (p. 13) often resulting in serious repercussions as to how they were then treated – which was frequently with the symptoms treated as innate pathology.<sup>167</sup>

Rosewater (1988) argued that, *"violence intensifies psychological disorders and symptoms, and abused women may appear similar to schizophrenic women on this major diagnostic scale,"* (p.13) and noted that women were frequently misdiagnosed with BPD, arguing that, *"these traits are not character traits, but reactive,"* and that *"the mental health system, in using such diagnostic tools can misinterpret what appears to be paranoia, in women who have every reason to feel fearful,"* (p.13).<sup>168</sup> Likewise, Taft (2003) suggests that, *"frequently mental health service providers do not understand the consequences of partner abuse or the implications of misdiagnosis for women with symptoms of mental disorders associated with domestic violence,"* (p.13).<sup>169</sup>

Sansone et al. (1995) who advocated the use of the diagnosis of BPD in women with symptoms resulting from childhood or adult violence or trauma, debated with Candib (1995) who objected to the diagnosis of BPD, arguing that the term implied failure to recover. She asserted that this and other stigmatising identifications afford no link to the relationship between abuse, trauma and a woman's response, or *"the context in which she makes sense of the risk to herself and those for whom she cares."* (p.17).<sup>170</sup> Such a diagnosis may result not only in an inappropriate or fragmented approach to treatment, but to broader ramifications such as losing custody of children or health insurance.

Herman (1992) proposed that the syndrome be called *"complex post-traumatic stress disorder,"* (CPTSD) since battered women suffer from a complex conglomeration of symptoms similar to PTSD but which include additional symptoms such as idealisation of the perpetrator and dissociation, due to the chronic nature of the trauma (see p.15).<sup>171</sup>

## Cost to the community

### Healthcare utilisation

Women with sexual assault and abuse histories, present with physical problems with greater frequency than those women who have not experienced sexual abuse. In addition to the conditions mentioned earlier in this review (p. 18), problems also include: diabetes; obesity; arthritis; asthma; recurrent surgeries; poor reproductive outcomes; digestive problems and hypertension.

Women with a history of CSA are also reported to experience even higher rates of numerous problems including: venereal disease; pelvic inflammatory disease; respiratory problems and neurological problems.<sup>172</sup> Consequently, it is not surprising that CSA is associated with increased healthcare utilisation and costs.

Walker et al. (1999), in a USA study, examined health care utilisation and found that women who reported a history of CSA were more likely to visit hospital emergency facilities, had annual total health care costs significantly higher than those without abuse histories and that these differences were observed even after excluding the costs of mental health care.<sup>173</sup> CSA survivors also appear to utilise high levels of health care (more physician visits and higher outpatient costs) than women who have been victims of other types of crime (Koss et al., 1991).<sup>174</sup>

### **The cost of mental health in Australia**

Whilst the consequences of CSA clearly contribute substantially to the costs of mental health care, the data available does not specify the causes leading women to access mental health services. However, the link between CSA, mental illness and related health problems has been demonstrated, and on the basis of these research studies one can speculate the extent to which costs might be minimised by expanding upon specialised services for survivors of CSA.

Based on figures in the National Survey of Health and Wellbeing (ABS, 1999), approximately 2.4 million Australians are thought to experience a mental health problem over any twelve-month period. Over one million are estimated to suffer from a mental disorder, with almost half affected long term.

Mental disorders accounted for almost 30% of the non-fatal burden of disease in Australia (1996). Depression is the most common mental disorder reported, both recently and long term (ABS, 1998b) and has been identified as the major focus of the mental health priority area (Department of Aged Care (DHAC) & AIHW, 1999c).<sup>175</sup>

Whilst affective disorders account for 33% of the burden, substance use disorders (24%) and anxiety disorders (23%), alcohol abuse accounts for 56% of the costs of mental health in Australia. The major cause of a mental disorder for females is affective disorders, accounting for 39% of women's mental health DALYs (total disability adjusted for life year). This is almost entirely depression (87%). The rate peaks in the age range 15 - 24 for both males and females.<sup>176</sup>

Mental illness is not a major cause of death but is a major cause of chronic disability. The cost of mental health disorders is dominated by years lost due to disability, which according to the Australian Bureau of Statistics (ABS, 1998b) in 1996 was 13.3% of DALY representing 0.8% of all deaths, 1.4% of years of life lost (YLL) and 27.2% of years lost due to disability (YLD).<sup>177</sup>

In 2001-02, total spending on mental health services was \$3.1 billion, a 65% increase in real terms since 1993. Nevertheless, specialised mental health services accounted for only 6.4% of Australia's recurrent health expenditure. An Australian Institute of Health and Welfare (AIHW) analysis showed that the proportion of mental health expenditure rises to 9.6% if substance abuse and dementia are included. Substance abuse accounts for 11.5% of the costs of mental health in Australia.

In a National report published by the Kids First Foundation (2003) highlighting the cost of child abuse and neglect in Australia, it was estimated that the cost to Australian taxpayers was approximately \$5 billion per annum. The long term human cost and cost of public intervention was estimated at three quarters of the annual cost, and the long term human and social cost at \$2 billion per annum.<sup>178</sup>

A study by United Kingdom National Commission of Inquiry into the Prevention of Abuse estimated that the cost of child protection services, as well as the additional mental health and correctional services associated with child abuse, was over one billion pounds per year in England and Wales.<sup>179</sup>

Similar figures also emerged from an American study, “*Prevent Child Abuse*” which conservatively claimed that US\$94 billion was spent annually in response to child abuse. Of this amount, 75% was spent on treating all the long term effects including: special education; mental and physical health care; juvenile justice; lost productivity and adult criminality.<sup>180</sup>

Total mental health expenditure allocated to the NGO sector (the only providers of services to adult survivors of CSA) averaged at 5.5% of the total mental health budget (2003-2005).<sup>181</sup> Expenditure in NSW was 2.4% as compared to 9.6% in Victoria.<sup>182</sup>

## **Data collection – The NASASV Project**

In 1993, the National Committee on Violence Against Women identified the need to improve and coordinate national data collection in relation to sexual violence. Following this recommendation, the Office of the Status of Women funded the development of a standardised minimum data set for collection of information by members of the National Association of Services Against Sexual Violence (NASASV).

As mentioned earlier, NASASV reported that *The National Data Collection Project: Snapshot Data Collection by Australian Services* (2000) represented a large sample of contacts, which included 60% (2,395) of survivors of sexual abuse from a diversity of services (51) over a three-week period. Whilst gender was not recorded in 6% of contacts, 85% were recorded as female contacts.<sup>183</sup>

NASASV recommended that further data collections should include expanded worker resources, which would generate greater service participation, including the potential for a broader scope of services to be involved in future. Ongoing data collection would include data useful to a broad spectrum of NGO and government services and be of enormous use in supporting initiatives for increased resources and proposals for policy implementation.

The project provided evidence supporting existing knowledge and ‘grass-roots’ observations gained in the Australian context about sexual violence. NASASV (2000) particularly highlighted information collected from the data such as: the gendered nature of sexual violence; the predominance of male perpetrators in positions of trust or relative power over the victim/survivors; and that the largest presentations being reported by adult survivors more than ten years after the abuse.<sup>184</sup>

Weeks (2001) presented some of the ethical dilemmas and findings in the NASASV Data Collection Project (2000) relating to access and equity practices in women and children from ATSI and CALD communities.<sup>185</sup> She suggested that the figures did not match the estimated degree to which sexual violence was experienced within these communities.

Unfortunately, whilst 40 organisations working with Aboriginal and Torres Strait Islander (ATSI) and NESB/CALD immigrant women were approached, they reported few responses. The full implementation of this data collection system could have significant benefits for the expansion of knowledge about sexual violence in Australia, with particular reference to minorities. The potential for utilising an ongoing data set to collect information for specific research studies on both a state and national level and the ability to isolate relevant material to a specific study is crucial.

## **Access and equity**

### **Access**

The *National Standards of Practice Manual: for services against sexual violence*. (NASASV, 1998) state as a principle that, “*Access implies recognising cultural diversity, and identifying and addressing barriers and structural disadvantages experienced by members of the community.*”<sup>186</sup>

Principles include equity of access to all potential users and must embody physical and geographic access and culturally appropriate advertising and information. Service providers must meet the needs of rural, regional and remote areas and no financial barriers should exist. Nor should there be barriers to psychological access due to associated stigma, inappropriate values or philosophy of management.<sup>187</sup>

An example of such barriers for women with disabilities was highlighted by the National Committee on Violence Against Women (1993). It identified six broad barriers to access:

- Lack of knowledge of the issue
- Lack of information about services
- Absence of physical access
- Inappropriateness of services offered
- Inappropriate values/philosophy of management
- Unsympathetic community attitudes.<sup>188</sup>

### **Equity**

The *National Standards of Practice Manual: for services against sexual violence* (1998) state as a principle that, “*Equity implies the fair treatment of all service users, a just allocation of resources and positive discrimination towards those facing additional barriers to services.*”<sup>189</sup> The manual stated that service provision must respect the cultural context of survivors - race, ethnicity, and language, and take into account factors such as age, gender, sexuality, intellectual and physical ability. Indicators in the manual refer to culturally appropriate practices and language.<sup>190</sup>

Weeks (2001) focused on whether ATSI and CALD women and children have access to fair equitable treatment and justice. She identified barriers in cultural practices and values, or ignorance of them, and attitudes stemming from racism and language. Whilst acknowledging the efforts for mainstream services to be culturally informed, aware and respectful of diverse cultures, she highlighted problems that exist for predominantly white workers to acquire extensive cultural knowledge and sensitivity towards other cultures.<sup>191</sup>

Amongst the many criticisms by black feminist writers in the USA dating back to the 1970s was an assumption that, *“Western models of resolving trauma and grief through counselling have universal application.”*<sup>192</sup> A feature of post-feminist critique has been to highlight these exclusionary tendencies within feminism itself.

Women of colour, lesbians and other marginalised groups have argued that mainstream feminists have minimised or ignored their particular problems and perspectives, *“failing to acknowledge their own situatedness and hence the ways they are implicated in and reproduce power relations — in this case, the presumptuous authority of white middle class heterosexual women to define ‘the standpoint of women’ — to speak for all other women and define who they are,”* (Collins Hill, 1990).<sup>193</sup>

## **Service provision**

### **Availability**

Women with CSA histories access services from a wide diversity of government, non-government and private health sectors. This diversity may include: mental health services; drug and alcohol; sexual assault; supported accommodation; employment; community and women’s health and counselling agencies; GPs; private psychologists; psychotherapists and counsellors; private hospitals and survivor support organisations.

Services in metropolitan and particularly in rural, regional and remote areas lack both the time and resources to undertake outreach work. Marginalised groups, especially Indigenous women, women with disabilities and women from CALD and NESB communities, as well as those living in rural or remote areas, are often unaware of the services available. Without the possibility of outreach work, the ‘accessibility’ of services is severely compromised.<sup>194</sup>

In order to provide services that meet the complex needs of this client group, it is imperative that practice is underpinned by a professional workforce - experienced, skilled and knowledgeable about the impact of CSA. A lack of funds to adequately invest in training and planning to capacity build result in a cycle of under-resourcing. At the *Home Truths* Conference (2005) long term workers in the field said that under-resourcing had become so widespread and had existed for so long, that it was becoming normalised.<sup>195</sup>

CSA survivors frequently have no subsidised access to counselling, and services with limited resources cannot meet the demand and prioritise services to assist those in crisis for 'recent assaults.'<sup>196</sup> Subsidised services under health funds rarely offer more than 6 or 8 sessions with a psychologist. Terminating treatment due to lack of resources can be re-traumatising.

Survivors consistently pinpoint a number of inadequacies in current service provision. These include difficulties in finding: expert, long term, affordable counselling; a lack of support groups and workshops; services that only offer a few sessions or telephone counselling; insensitivity and/or ignorance within generalist health services and inadequate training and responses from a wide spectrum of specialist services, such as drug and alcohol and mental health services.<sup>197</sup>

In a submission to the State Budget (2004), The Council of Social Service, NSW (NCOSS) stressed the need for increased access to support services for adult survivors (without decreasing access to services for recently abused children and adults). They suggested that additional funding for rural support services to adult survivors would minimise the impact on physical and mental health, substance dependency, and the demand on crisis and other mental health services.<sup>198</sup>

### **Separate services for survivors of child sexual abuse**

It has been suggested by some survivors that separate agencies are vital for them to feel 'safe.' A 'safe place' is an environment that is unlikely to further 'trigger' traumatic memories and responses. Entering premises in which children of ages reminiscent of the age of their own abuse are also being counselled may evoke traumatic memories for some survivors.<sup>199</sup>

Whilst some Government agencies provide free short-term counselling (usually 6 or 8 sessions) for survivors, the support required for most clients is long term. It is inappropriate to engage with a client and then be unable to offer them the long term support they need, which could be perceived as '*another*' rejection or result in feelings of abandonment.<sup>200</sup>

### **Practice standards**

Over the past decade numerous documents both State and Federal have outlined proposed standards and guidelines for service delivery. Despite the publication in 1998 of the thorough and extensive national standards manual for sexual assault services, funded by the Office of the Status of Women and Department of the Prime Minister and Cabinet, and auspiced by the Centre against Sexual Assault (CASA), a national policy has not been fully implemented.<sup>201</sup> Whilst all States have implemented some standards and guidelines, either as a consequence of a political imperative such as institutional abuse, or because of a particularly localised need, full endorsement of a National policy has not occurred.

The National Association of Services against Sexual Violence (NASASV) in their *National Standards of Practice Manual: Access and Equity, Standard 1* (1998) states that the manual seeks to: “reflect the priorities of services and commonality of experiences and responses to sexual violence.”<sup>202</sup> Despite the lack of resources, service providers report that they utilise these standards and guidelines as benchmarks for measuring service delivery.

The NASASV Manual applies access and equity principles, a human rights approach, and recommends ethical and sensitive service provision for both adult and child victim/survivors. It is imperative that these principles inform future recommendations on the standards and guidelines and are embodied in legislation and implementation strategies:

*“The Service against sexual violence works to ensure the accessibility and appropriateness of its service delivery to all those victim/survivors in its community, whether they are women, children or men.*

*Access implies recognising cultural diversity, and identifying and addressing barriers and structural disadvantages experienced by members of the community.*

*Equity implies the fair treatment of all service users, a just allocation of resources and positive discrimination towards those facing additional barriers to services.*

*Service provision respects the cultural context of victim/survivors such as their race, ethnicity and language, and factors such as geographical location, socio-economic background, gender, age, sexuality and level of ability.”*

**NASASV. (1998).**<sup>203</sup>

***National Standards of Practice Manual: for services against sexual violence.***

The NASASV Manual (1998) also identifies and endorses standards for community and professional education, for securing reform of the systems encountered by victim / survivors and for undertaking and participating in research. These standards also focus on organisational context and emphasise the need for adequate resourcing to ensure the efficient and accountable operation of all programs.<sup>204</sup>

Whilst NSW Department of Health have produced *Guidelines for the promotion of sexual safety in NSW Mental Health Services* (Second Edition: 2004), there is no reference to safety issues for adult survivors.<sup>205</sup>

### **Preferred model of access**

Weeks (2001) debates whether the preferred model of access is one that expands on mainstream services, or whether women should be supported to build their own culturally appropriate services. Advocating that service delivery must be resourced and structured to take into account all factors such as geographical location or diversity of community, she supports a set of principles based on an understanding of difference - an approach that does not attempt to merely include women of other cultures to organisations constructed in the manner of dominant culture services.<sup>206</sup>

Discussing whether ethno-specific services can best meet immigrant women's needs, Garrett (1992) comments that, "*ethnocentrism, racism or simply insensitive treatment within mainstream organisations and by middle-class feminists has at times caused immigrant women to establish their own services.*"<sup>207</sup>

However, Garrett (1992) acknowledges the difficulties in supporting large numbers of diverse cultural groups with specialist knowledge and skills and assumes that, "*services need to employ language-specific mediators – either bilingual sexual abuse workers, interpreters or sessional bilingual welfare workers.*" NASASV (2001) recommended the following initiatives grouped into nine major strategies:<sup>208</sup>

- Outreach and Community development projects
- Media, communication and educational strategies
- Developing access and equity strategies within sexual assault services, and designating an access and equity worker position
- Working with cultural consultants within service governance
- Employing Aboriginal workers
- Employing ethnic minority workers
- Collaborative projects
- Workers in Aboriginal specialist organisations
- Workers in Immigrant women's organisations

### **Barriers to access**

In, *Cultural Diversity and Services Against Sexual Violence*, NASASV (2002) states that barriers to access in mainstream services are frequently due to, "*racism and ignorance about the cultural practices of others reflected and embedded in individual worker's practices, as well as systemic arrangements.*"<sup>209</sup>

Clark, Andrews and Austin (2000) reporting on the experiences of Indigenous people attending mainstream hospitals, expressed concerns at being labelled and stereotyped, misjudged or misunderstood, or not presenting in a way that was seen as '*correct.*'<sup>210</sup>

Reporting on The Dulwich Centre Links Project, Wingard and Lester (2000) identify five factors in the alienation of potential ATSI service users: -

- Attitudes of non-Aboriginal workers and practices such as: 'prying' into personal details; disrespectful language; not seeking permission before taking action and not ensuring that people understood what was being proposed before proceeding
- Attitudes of other people using the services towards ATSI clients
- Absence of ATSI staff
- Alienating physical layout of service
- Organisation practices, such as: lack of flexibility, length of time allocated and lack of home visiting practices<sup>211</sup>

The NASASV report *Cultural Diversity and Services Against Sexual Violence* (2002) noted that 4% of service users in NSW Sexual Assault Services in 1994 were immigrant women, in spite of their being 15% of the population.<sup>212</sup> They identified the cultural and structural barriers with regard to sexual assault, some of which could be suggested as equally relevant to survivors of CSA:

- Fear and shame
- Language barriers
- Fears about lack of confidentiality, (bilingual interpreters may be well known within their community)
- A poor understanding that services are available, and that they are free
- Lack of cultural sensitivity by service providers<sup>213</sup>

The Victorian Foundation for Survivors of Torture and the West Melbourne Division of General Practice (2000) highlight the presence of mental health problems for refugee clients.<sup>214</sup> Providing access and equity to all survivors must include an acknowledgement that immigrant and refugee women may also be victims of torture and trauma prior to resettlement. Such factors must be taken into account when providing workplace training and education and delivering appropriate services to culturally diverse clients.

In a guide and study into caring for refugee clients, The Victorian Foundation emphasise the importance of engaging professional interpreters and providing adequate education, information and of, *“always maintaining a high level of expectation that abuse may have occurred, which led directly or indirectly to physical and mental problems or both,”* since clients may or may not disclose episodes of extreme abuse such as CSA or torture.<sup>215</sup>

### **Consumer participation**

One of the core principles of equity in the *Consumer and Carer Participation Policy: A Framework for the Mental Health Sector. Best Practice Principles for Inclusion in a Participation Policy* (2004), was development for consumer participation in the mental health sector.<sup>216</sup> The principal involves promotion through practice, and participation in all processes that affect survivors' lives. This should not be forgotten or ignored in relation to survivors of CSA.

The acknowledgement that survivors provide unique understanding due to their lived experience, is paramount to empowering women to contribute to service delivery planning, education and training, evaluation and involvement in improving quality outcomes and promoting access and equity.

### **Integrative collaborative practice**

Partnerships are usually marked by referral or loose agreements between agencies and are frequently based on the goodwill of individuals and unsustainable.

The negative experiences by survivors of CSA in their interactions with mental health services, expressed anecdotally, justify the formation of collaborative practices between a diversity of community based NGOs, building capacity and developing stronger links between NGOs and the mental health sector. These practices require formalised relationships, agreed standards and guidelines for service delivery policy and implementation.

In the absence of evidence regarding partnerships and service collaboration for survivors of CSA, the area of domestic violence and sexual assault present an opportunity to learn from some relevant similarities. Warshaw and Moroney (2002) suggest treatment models need to find ways of integrating service responses that reflect social and advocacy requirements, as well as psychological needs, and that issues around current as well as past abuse are addressed.<sup>217</sup>

A number of international studies identify barriers to successful collaboration reported by advocacy and domestic violence service providers. Determining providers' concerns regarding the complex mental health needs of their clients, and the barriers they envisaged to successful collaboration, four areas emerged (Keel, 2005):

- Limited resources and training
- That the move towards a mental health model of intervention might result in pathologising and stigmatisation
- That mental health screening might alienate women who only seek refuge and support
- That mental health responses may minimise the advocacy aspect of the work<sup>218</sup>

Comparative research to the study conducted by Warshaw and Maroney (2002) is exceptional. However, a Victorian Department of Human Services (DHS) report in 2004, explored partnerships between sexual assault, mental health and domestic violence services.<sup>219</sup> The project, *Partnerships between Mental Health, Family Violence and Sexual Assault Services Project* (2004) showcased Victoria's best practice models of partnership.<sup>220</sup> A number of obstacles identified by Victorian services were similar to those discussed by Warshaw and Maroney (2002).<sup>221</sup>

It was noted that, that at a policy level, it was unclear as to who is responsible for education and how to collaborate at a state and regional level. Obstacles to success included:

- Senior managements' failure to endorse and support collaborative efforts, resulting in an ad-hoc approach
- A lack of staff expertise in the areas of sexual abuse/family violence or mental health issues was seen as a barrier to good working relationships across the sectors
- A negative attitude to the philosophical and language differences across service models and frameworks
- The presence of a hierarchy in some professions, and disregard of expertise in other sectors
- A shortage of resources

- That particularly for Aboriginal women, a lack of culturally appropriate responses from some mainstream organisations, discouraged staff from working collaboratively<sup>222</sup>

The Victorian project identified factors conducive to successful collaboration which could prove appropriate for services working with survivors of CSA. An organisational culture, *“that encourages, supports and influences new ideas and collaborative processes was integral to developing relationships across sectors, trained staff that endorse and support the process, who respect others’ work and expertise, and recognition of each others’ limitations, and a move towards expanding pathways to move beyond the parameters that had originally shaped the scope of their service provision,”* (Keel, 2005).<sup>223</sup>

Keel (2005) writes that the Governments’ response to the growing evidence about the association between sexual assault and mental health has been slow, and the link between CSA and mental illness has evoked even less reaction.<sup>224</sup>

The list of recommendations designed to assist in the provision of appropriate service responses, specific to sexual assault, was published within the conference proceedings of the, *‘Women and Mental Health: After Burdekin,’* (1994). Some of the recommendations are relevant to service provision for survivors of CSA, for example: training of mental health professionals on the social and political context of sexual abuse (transpose CSA); the effects of sexual abuse (transpose CSA); the appropriateness of psychiatric diagnoses, and the need for mental health professionals to use community services and referral systems.<sup>225</sup>

In addition, a recommendation was proposed to develop a national database of services to facilitate collaborative practices and referral pathways, and to share information on research and workforce training. This could provide a valuable resource for data collection for outcome measurement and longitudinal studies. A database made available to professionals and consumers across all sectors, including those working with survivors of CSA would be invaluable.

### **The Jacaranda Project**

The ‘Reframing Responses’ project has reviewed a number of worthy programs and projects internationally and in Australia that promote a ‘holistic’ approach to service provision and interagency ‘capacity building.’ The most notable example in Australia is the **Jacaranda Project**, which was developed and established by North Sydney Health Sexual Assault Service in 1997.

Responding to the well-documented negative impact of CSA on physical and mental health, the project endeavoured to design and provide an efficacious, cost effective model of service delivery to a ‘high-risk’ group of clients. With minimal funds, an extensive project was developed and implemented. This included a management committee, facilitators’ handbook, group leaders’ training, contracts and supervision. Critical to the project was capacity building and networking between health and community services to provide interventions for survivors of CSA. This was successfully initiated and implemented.

In 2001, the project's first evaluation was published (a second study is in progress). Nine groups consisting of adult survivors had taken place, 51 women having completed the group program. The evaluation provided an accurate record of activity, expenditure, outcomes, and an opportunity to refine, improve on, and measure the project's performance against key Area Health Service and NSW Health Department policies and directions.

These included:

- Formation of partnerships and inter-sectorial collaboration
- Capacity building
- Preventing crisis and social disadvantage (if CSA remained untreated)
- The establishment of a model of best practice
- The maintenance and continuity of care
- An evaluative process that measured long term outcomes

Overall, the outcome evaluation concluded the Jacaranda Project to be a highly successful initial project, thus validating the best practice model developed. The project had succeeded in meeting its own and broader State health service criteria.

Most of the problems identified with infrastructure were attributable to inconsistent funding, and it was felt that numerous improvements could be made in recruitment, project structures and management. The evaluation stated that given the success of capacity building, further expansion and an extended project would provide the potential to change the culture, to achieve greater 'ownership' of service provision, and deliver high quality and evidence based practices to CSA clients across a wide range of services.

The groups were described as an overwhelming success, although the evaluation noted that the project would benefit by working towards facilitating groups across a broader section of the community. They also stressed that to maximise effectiveness, the project should be re-positioned so that it was 'owned' by a wider range of service streams within the health service, and that it was important that those services who have a large proportion of CSA survivors among their clients, become key partners in the project.

**McMaugh, K. (2001). *The Jacaranda Project: for survivors of child sexual abuse.***  
Evaluation Report: Northern Sydney Health Sexual Assault Service.<sup>226</sup>

## Conclusion

Recent studies have demonstrated specific and direct causal pathways from CSA to adult psychopathology (Kendler et al., 2000).<sup>227</sup> According to NSW Health (1997:1998) survivors of CSA accounted for 34% of all presentations across the sector.<sup>228</sup> Research has consistently shown that survivors have high rates of mental illness, suicide, substance abuse and poor physical health. Survivors of CSA constitute the greatest number of women that request services both from the NGO and mental health sectors. Many survivors present with health issues, they have not identified as being related to their childhood abuse.<sup>229</sup>

The Australian Community Sector Survey (2006) stated that when agencies were asked to list priority services their clients most needed (other than their own), they identified mental health and drug and alcohol services and long term accommodation as most important. These were followed by income support crisis and supported accommodation.<sup>230</sup>

Research has identified 'evidence-based' best practice as an approach to service delivery for survivors of CSA that offers a range of flexible 'holistic' services. As a consequence of under-resourcing, and the need to respond to those in crisis, as a rule, State Government Sexual Assault Services are unable to offer counselling to adult survivors. NGO community based services play a crucial role in responding to the complex needs of survivors of CSA who experience difficulties in accessing government mental health and welfare services. *"Responses should be guided by coordination of effort, common sense and compassion,"* (Raphael & Newman, 2000).<sup>231</sup>

It is clear that increased access to support services for survivors of CSA in Australia is urgently needed, without decreasing access to recently abused and assaulted children and adults. The **"Reframing Responses"** literature review, when combined with qualitative data, will provide the basis for recommendations to Government that improve access and equity of service provision to this population in the community.

On the basis of the evidence informing this study, recommendations are likely to include effective dissemination of information, support and culturally appropriate counselling and therapeutic services, embodied in a model of sustainable collaboration and capacity building between a diversity of NGO services such as the Jacaranda Project, a model easily transferable to the NGO sector.

It is clear from existing evidence, that recommendations for improved service provision must emphasise the need for relevant education and workplace training across many areas including: mental and physical health issues for CSA survivors; substance dependency; domestic violence; sexual assault; homelessness; learning difficulties; poverty and birthing and parenting problems.

The implementation of National Standards and Guidelines embodied in Government policy is crucial - setting outcomes and including evaluation and ongoing improvements in service delivery, data collection for longitudinal studies for research and outcome measurement. A commitment to quality service delivery across the State will need to address service delivery to rural, regional and remote communities and isolation of rural workers.

The primary objective of the **"Reframing Responses"** project is to provide unequivocal evidence that the complex needs of survivors of CSA can no longer be ignored in terms of the human and long term cost to the community. This review has identified a lack of information in an Australian context with regards to service delivery, organisational structures and the perceptions of service providers and survivor users of services. The 'Reframing Responses' project has sought to provide evidence in NSW that will demonstrate the need for improved access and equity to a group most marginalised and vulnerable as a consequence of mental illness, substance dependency, co-morbidity, ethnicity, socio-economic status, disability or sexual preference.

## Appendix 1

### Treating adult survivors – Methodologies

Many models, therapeutic approaches and techniques are used by health professionals who work with survivors of child sexual abuse. Clients present for treatment at different stages of recovery, with variable symptomatology, coping and functionality. Many approaches are integrative or eclectic and demonstrate responses to individual client needs during the healing process. This review has selected a few modalities that are most commonly used in government and community services nationally and internationally, often used integratively or as specific therapeutic models.

#### Pharmacotherapy (Medication)

Medication can minimise the anxiety, depression and insomnia often experienced by survivors of CSA. In some cases of PTSD it may help relieve the distress and emotional numbness caused by traumatic memories. Several types of antidepressants have proved beneficial in most (but not all) clinical trials and other classes of medication have shown promise. No single medication has emerged as a definitive treatment for PTSD. However, medication is useful for symptom relief, enabling patient/survivor participation in psychotherapy.<sup>232</sup>

#### Cognitive Behavioural Therapy (CBT)

CBT frequently used together with medication is one of a number of interventions considered to represent 'the medical model.' CBT works with cognitions to change emotions, thoughts and behaviours. In a safe, controlled context, the client is encouraged to face and gain control of the fear and distress that was overwhelming during the trauma. With clients who experience PTSD as a result of a traumatic event such as a natural disaster, it is usual to progressively expose the client towards the trauma, using relaxation techniques, "*taking the trauma one piece at a time (desensitization).*"<sup>233</sup> The CBT model when used with survivors of CSA usually focuses on the 'here and now' rather than revisiting the trauma itself.

CBT for trauma includes learning how to cope with: anxiety and negative thoughts; managing anger; preparing for stress reactions; handling future trauma symptoms; addressing urges to 'self-soothe' with alcohol or drugs and communicating and relating effectively with people.<sup>234</sup>

#### Critique of the medical model

CBT is considered by many professionals as a 'band aid' that fails to address the impact of long-term trauma experienced by most survivors of CSA. Many practitioners feel that concepts of 'faulty thinking and patterns of behaviour' are inappropriate to this client group. Whilst some psychiatrists and psychologists encourage survivors to empower themselves, and are empathic and sensitive to the dynamics of abuse, there is little research measuring the effectiveness of this intervention.

In a *National Inquiry into the Human Rights of People with Mental Illness*, a report of tabled in Parliament in 1993, Commissioner Brian Burdekin wrote, “*some professionals place an over reliance on symptomatology and purely medical models to the exclusion of psycho-social and environmental factors in diagnosing psychiatric disorders in women,*” (Ch, 5). He called for preventative counselling for women who have experienced all forms of sexual abuse and violence.<sup>235</sup>

The medical model is inclined to support the theory that abuse memories are fantasies, and treat symptoms such as depression with medication, as opposed to validating and exploring women’s subjective experiences.<sup>236</sup>

Whilst all modalities have their critics, the medical model has been highlighted here because it is the dominant model utilised by clinicians working in mental health settings, particularly for depression and anxiety disorders and is almost universally criticised by therapists working with survivors of CSA.

Since the 1960s, anti-psychiatry and ‘post-psychiatry’ movements have critiqued hierarchies of power (Bracken & Thomas, 2001).<sup>237</sup> The principal critique relates to coercive elements of practice, suggesting that only when coercive psychiatry is abolished can the moral powers of ‘uncoerced’ psychotherapy be released (Szasz, 1997).<sup>238</sup> The ‘medical model’ of psychiatry is seen as more likely to serve as a model of social control by individualising society’s sickness and diagnosing it to be treatable by the medical profession.

### **Dialectical Behaviour Therapy (DBT)**

DBT is a skill-based therapy developed by Dr. Marsha Linehan (Department of Psychology, University of Washington) providing practical and effective coping techniques. Whilst this modality has its critics, such as Peter Fonagy (1999),<sup>239</sup> it is a treatment currently considered by many as ‘best practice’ in helping clients (particularly those diagnosed with BPD) who may engage in life-threatening behaviours to cope with intense and unstable emotions. These behaviours frequently include: self-harm; suicidal acts; impulsive behaviours such as substance abuse; eating disorders; or engaging in an unsafe lifestyle.<sup>240</sup>

DBT uses a cognitive behavioural approach that includes a strong emphasis on acceptance of the person as they are, combined with the expectation that current behaviours need to change. The tension that arises between this need for both acceptance and change is known as a “dialectical tension.”

Dialectics refers to finding the middle ground between two opposites.<sup>241</sup> “*Acceptance strategies are drawn from Zen practice, and involve emotional, behavioural and cognitive validation whilst teaching the client personal strategies for validation,*” (Murphy & Gunderson, 1999).<sup>242</sup>

DBT is usually at least a one-year treatment, involving considerable commitment on the part of both therapist and client. Concurrently, the client learns techniques such as 'mindfulness, interpersonal effectiveness and emotion regulation in a 'skills group,'<sup>243</sup> whilst undergoing individual therapy and receiving support (between sessions) via telephone consultations. This model is a costly and primarily only available in Australia in the private sector, although a few agencies have begun piloting it in the public sector.

### **The Self-Trauma Model**

Referred to as the *self-trauma model*, Briere (1992:1996) has integrated facets of trauma theory in addition to CBT, behavioural therapy and self-psychology. Whilst this perspective appears to be unreservedly cognitive-behavioural, it endeavours simultaneously to, "*re-conceptualise psychodynamic therapy to encompass empirically based principles as they relate to child abuse.*"<sup>244</sup>

Self-trauma theory is founded on notions of suppressed or 'deep' cognitive activation (Wegner & Smart, 1997), relational schema (Baldwin, Fehr, Keedian, Seidel & Thompson, 1993), and the role of early attachment experiences on emotions, beliefs and recollections (Simpson & Rholes, 1998).<sup>245</sup>

This theory embodies a growing awareness that implicit memories are at least as significant as, "*cognition in understanding and treating anxiety-based disorders,*" (Foa & Kozak, 1986; Samoilov & Goldfried, 2000, Westen, 2000).<sup>246</sup> The intentions of the model are represented in terms of the specific process, content and goals of abuse-relevant psychotherapy.

### **Post-Traumatic Stress Model**

The relationship between CSA and adult psychopathology was initially conceptualised in terms of chronic PTSD, and focused on trauma-induced symptoms, particularly dissociative disorders, amnesias, fugues and even multiple personality. The theory proposed that the stress-induced symptoms engendered during the abuse reverberated to produce a post-abuse syndrome in adult life. (Lindberg & Distad, 1985, Bryer et al., 1987, Craine et al., 1988).<sup>247 248 249</sup>

In its more refined form this model attempts to, "*integrate the damage inflicted at the time to the victims' psychological integrity, by the child sexual abuse and the need to repress the trauma, with resultant psychological fragmentation.*"<sup>250</sup> This fragmentation later manifests itself in mental health problems and problematic interpersonal and sexual adjustment in adulthood (Rieker & Carmen, 1986).<sup>251</sup> This model has found strongest support in the observations of clinicians dealing with individuals with histories of severe and repeated abuse.<sup>252</sup>

### **Traumagenic Dynamics**

In the United States, a less medicalised model, for the mediation of the long term effects of CSA was proposed by Finkelhor (1987). His '*traumagenic dynamics*' model asserts that the attitude of the survivors to self and others, is characterised by traumatic sexualisation, a sense of powerlessness, stigmatisation and betrayal.

Finkelhor (1987) wrote that, *“Traumatic sexualisation leads to sexual inhibition, fears of intimacy, sexual precocity, and promiscuity. Powerlessness leads to passivity and avoidance. A sense of stigma can lead to social withdrawal, guilt, shame, suicidality, and substance abuse. The sense of betrayal causes a persistent suspicion of others, fear of intimacy, and vulnerability to later sexual abuse,”*<sup>253</sup>

However, the model does not differentiate between stressor and stress responses, and fails to identify which features of sexual abuse are related to which of the tetrad of dynamics.<sup>254</sup> Finkelhor (1997) proposed the model as an alternative to the PTSD model which he contended, failed to account for the victim's attitudes to herself and others.

Whilst emphasising the psychological ramifications of the abuse, Finkelhor (1997) barely acknowledged the social dimensions. Only recently have attempts been made to, *“articulate the long-term effects of child sexual abuse within a developmental perspective and to attend to the interactions between child sexual abuse and the child victims' overall psychological, social and interpersonal development,”* (Cole & Putnam, 1992).<sup>255 256</sup>

Spaccarelli (1994) suggests that Finkelhor's model and the PTSD model are complementary, in that the traumagenic dynamics model focuses on attitude to self and others, and the traumatic stress model focuses on the psychobiological manifestations of the traumatic state.<sup>257</sup>

## **Eye Movement Desensitization and Reprocessing (EMDR)**

EMDR is a treatment that facilitates the accessing and processing of traumatic material. It involves elements of exposure therapy and CBT combined with techniques (rapid eye movements, hand taps, sounds) that create an alternation of attention back and forth across the person's midline.

Whilst the theory and research are still evolving for this treatment and controversy abounds,<sup>258</sup> there is some evidence that the therapeutic element unique to EMDR enables clients to reduce trauma symptoms to such an extent that they can think about the events with almost no emotion.<sup>259</sup>

## **A Transactional Model**

An integrated framework for understanding stress and coping for survivors of CSA is embodied in Spaccarelli's (1994) transactional model, which suggests that, *“the outcome of sexual abuse is determined by a transactional matrix of factors,”* each of which is variable.<sup>260</sup>

Sexual abuse should not only be understood in terms of onset, frequency and severity, but in terms of the systemic environment that shapes the child's internal resources, and in turn, interacts with it. The risk of poor outcome increases as a function of the stress involved in both the abuse experience itself, and events related to the abuse (Nurcombe, 2005).<sup>261</sup>

Nurcombe (2005) suggests that, *“the outcome of abuse is determined by multiple, complex, reciprocal transactions between moderating variables, the abuse experience, events related to the abuse (and its disclosure or non-disclosure), and mediating variables.”* The effect of abuse stress is mediated through the child's appraisal of self and other, and the coping strategies used to adapt and survive are moderated by developmental level, attributional style and family support (or lack thereof).<sup>262</sup>

## **Narrative Therapy**

Johnella Bird (2000, 2004) has been extremely influential in the development of narrative therapy in the context of trauma. Her approach is one of relational ethics and relational externalisation, underpinned by feminist and narrative practices which focus on the power dynamics in a therapeutic relationship. The objective is to utilise the relationship so that the client can acquire agency in all areas of their life.<sup>263</sup>

Narrative therapy for survivors is usually understood in the context of a feminist framework, with a strong belief in a collaborative approach. The therapeutic environment is developed, *“...using a feminist model that employs principles such as pluralism, egalitarianism, and building on strengths to create a more inclusive, safe and empowering environment that promotes shared decision-making... Participants are trusted with their own process, while facilitators provide support,”* (Asher et al., 1994).<sup>264</sup>

Michael White (1992) wrote that it is through narrative or stories that we learn about others and ourselves, and construct meaning of our experiences. *“These stories largely determine which aspects of experience persons select out for expression...”* These constructions shape how people live their lives and, *“have real, not imagined effects.”*<sup>265</sup>

Narrative therapy promotes a core belief that individuals are, *“the experts in their own lives and view problems as separate from people.”* People *“have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives,”* (Morgan, 2000).<sup>266</sup>

By understanding and re-authoring, healing can occur through particular ‘tellings’ and ‘retellings.’ Sometimes referred to as ‘narrative practices’ rather than ‘narrative therapy,’ it is an evolving process that engages in a complexity of different contexts. *“It is a way of working that is interested in history, the broader context that is affecting people’s lives and the ethics or politics of therapy,”* in which people engage their own individual manner.<sup>267</sup>

## **Group Therapy**

Survivors frequently report the efficacy of a therapeutic setting in which the safety, cohesion and empathy provided by other survivors enables group members to share traumatic material. *“As group members achieve greater understanding and resolution of their trauma, they often feel more confident and able to trust. As they discuss and share how they cope with trauma-related shame, guilt, rage, fear, doubt, and self-condemnation, they prepare themselves to focus on the present rather than the past,”* (Fleming et al., 2005).<sup>268</sup>

Group therapy particularly suits survivors of CSA who have already been in counselling or therapy, and have dealt with issues of trust with which many survivors grapple. Ideally group participants also have an individual therapist to help process the material the group share.

Telling one's story (the 'trauma narrative') and directly facing the grief, anxiety, anger, betrayal and guilt experienced related to the abuse, enables many to cope better with symptoms, memories and other issues such as substance abuse and relationship problems. "*Persons give meaning to their lives and relationships by storying their experience...and in interacting with others in the performance of these stories they are active in shaping their lives and relationships,*" (White & Epston, 1989).<sup>269</sup>

### **Person Centred and Humanist Therapy.**

'Person centred' models share a vision of psychology embodying recognition that all individuals have a capacity for creativity, growth and choice, primarily influenced by the traditions of existential and phenomenological philosophy - the individual as self-striving to find meaning and fulfilment in the world.

Person centred counsellors and psychotherapists generally work in an integrative or eclectic way, providing emotional support and assessing individual and changing needs during the course of therapy.

Whilst conveying an authentic presence, the focus is on the subjective experience of the client, rather than imposition of personal definitions and structures. Of primary importance is the 'therapeutic alliance' – the development of a trusting relationship between a client and the therapist (McLeod, 2003).<sup>270</sup>

### **Psychotherapy**

Psychotherapy is a broad term for a range of models of therapeutic endeavour in which the therapist creates a 'safe space' within which individuals or groups can explore feelings, experiences and behaviours, and understand how they impact on the 'self'. The psychotherapeutic relationship is the key element of the process rather than a specific set of techniques (Kaplan, 1991).<sup>271</sup> Psychotherapists understand the way the self of the therapist impacts upon the self of the client, and vice versa, and uses that knowledge to enable the client to explore their responses to relationships and the environment, and to make links with past experience.

Psychotherapy has been demonstrated to be valuable to people diagnosed with BPD (Stevenson & Meares, 1999).<sup>272</sup> The relational framework upon which psychotherapy is based that includes self, other, transference, countertransference, idealisation, empathic attunement, and emotional support, has been used as the basis for many 'talking therapies' and counselling models.

## **Brief Psychodynamic Psychotherapy**

Brief psychodynamic psychotherapy (6 -12 sessions) focuses on the emotional conflict caused by traumatic events, particularly as they relate to early life experiences of abuse. Through the development of the 'therapeutic alliance' with a calm, empathic, compassionate and non-judgmental therapist, survivors can enhance their self-esteem, develop effective ways of thinking and coping and learn to deal more successfully with intense emotion. The therapist works with survivors to identify current life situations that 'trigger' traumatic memories and worsen PTSD symptoms.<sup>273</sup>

## **Mind/Body Psychotherapy – Trauma Model.**

Mind/body psychotherapy is an eclectic approach in which the practitioner continually evaluates the most effective interventions for trauma related problems. The aim is to enable clients to move from being, *"haunted by the past and interpreting subsequent emotionally arousing stimuli as a return to the trauma, to being present in the 'here and now,' and capable of responding to their fullest potential,"* (Van de Kolk et al., (1996).<sup>274</sup>

Clients are helped to regain control over emotional responses and place the trauma in its historical context. The 'therapeutic alliance' and development of trust is crucial to effective treatment. The model draws the best resources from verbal and body psychotherapies, and uses them to identify, understand and treat traumatic effects on both the mind and body (Rothchild, 2000).<sup>275</sup>

The concept proposes that the *"The Body Remembers"*<sup>276</sup> and becomes a resource in the treatment of trauma. By understanding how the brain and body process, remember and perpetuate traumatic events, the client learns how to regulate affect and pain.

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