

REFRAMING RESPONSES STAGE TWO: SUPPORTING WOMEN SURVIVORS OF CHILD ABUSE

An Information Resource Guide
and Workbook for Community
Managed Organisations



Mental Health
Coordinating Council

Reframing Responses Stage 11: Supporting Women Survivors of Child Abuse. An Information Resource Guide and Workbook for Community Managed Organisations

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Authors: Corinne Henderson and Jenna Bateman

With the collaboration of **Adults Surviving Child Abuse (ASCA)**



Jenna Bateman

Chief Executive Officer – Mental Health Coordinating Council

Corinne Henderson

Project Coordinator

Senior Policy Officer – Mental Health Coordinating Council

Acknowledgement

Corrective Services NSW – Victims of Violent Crime Grants Program for funding this project.

Victims of Violent Crime Grants Program assists not-for-profit, community agencies working with victims of violent crimes by providing small grants for one-off projects. The program provides opportunities through profits from prison labour programs, to make reparation to the community through financial assistance to victims of crime support organisations.

Cautionary note: This resource contains some confronting material and we urge readers to pay attention to self-care. The section on Vicarious Traumatization and Self-Care (section 8.3) is a useful guide to all workers in the field; many of whom we acknowledge may be survivors themselves.

FOREWORD

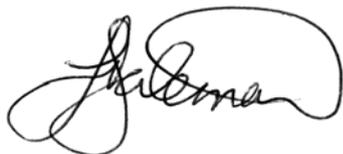
In 2006, the Mental Health Coordinating Council (MHCC) secured a grant from the Victims of Violent Crime Grant Program to conduct a research project *Reframing Responses: Improving service provision to women survivors of child sexual abuse who experience mental health problems* (2006). This project undertook to study the capacity across and between non-government organisations to provide services to women survivors of childhood sexual abuse with complex needs, by evaluating existing service delivery. It aimed to develop an understanding of safety issues, models of care and identify gaps, inequalities and barriers to access as well as to provide recommendations for service delivery.

The project also sought evidence in NSW to demonstrate the need for improved access and equity to this group marginalised and vulnerable as a consequence of mental illness, substance dependency, co-morbidity, ethnicity, socio-economic status, disability or sexual preference. The first stage was coordinated by MHCC with Louise O'Brien, Professor of Nursing Charles Sturt University, engaged at the time as consultant to the project. Louise was then Associate Professor Nursing, University of Western Sydney.

Subsequently, the Victims of Violent Crime Grant Program provided funding for stage two of the project: *Reframing Responses Stage 11: Supporting Women Survivors of Child Abuse: Information Resource Guide and Workbook for Community Managed Organisations*. The project aims are to assist those working in a broad range of community services to understand the dynamics of childhood abuse, assisting them to make sense of the context in which problems affecting their clients developed.

The Information Resource Guide provides workers with practical guidelines to assist survivors along their pathway to recovery and aims to inform and support the many community services in daily contact with adult survivors presenting with complex needs which require referral to other services. The Workbook includes some reflective practice exercises for workers to consider and discuss with colleagues.

Our objective is that the Information Resource Guide and Workbook will serve as an invaluable resource for a wide range of community managed organisations as well as: medical practitioners and allied health professionals, school teachers, volunteers, carers and anyone in contact with survivors in their work. Survivors may also find the Workbook a useful tool which both acknowledges and validates their experience, and may assist them in their role as consumer advocates.



Jenna Bateman
Chief Executive Officer

RESEARCH REFERENCES

Much of the material in this Information Resource Guide and Workbook is informed by the literature review conducted at stage one of the project, *Reframing Responses: Improving Service Provision to Women Survivors of Child Sexual Abuse who experience Mental Health Problems* (MHCC, 2006). It also includes more recently available research evidence statistical data.

This Information Resource Guide and Workbook has been developed in collaboration with ASCA (Adults Surviving Child Abuse), who together with MHCC developed and facilitated a two-day training workshop and manual for community service providers for MHCC's Learning and Development Unit (LDU). A substantial amount of the content of the Workbook has been drawn from this resource.

ACKNOWLEDGEMENTS

The MHCC would particularly like to thank member organisation ASCA and its management team for their considerable contributions to the Reframing Responses project and to ASCA Research and Program Manager Dominiek Coates for her work on the original training workshop manual for the MHCC LDU workshop.

We wish to thank and pay special tribute to the many survivor participants to both stages of Reframing Responses who generously shared their unique experiences with us, and to the service providers, supporters and many contributors to this project.

We particularly thank the following organisations and individuals for their contributions to both stages of the Reframing Responses Project:

Adults Surviving of Child Abuse (ASCA) – Dr Cathy Kezelman, Dominiek Coates, Susan Leith-Miller, Lorraine Wright

Charles Sturt University – Associate Professor Louise O'Brien

Education Centre Against Violence – Joanne Campbell

Justice Health Centre for Health Research in Criminal Justice – Dr Devon Indig

MHCC Learning & Development Unit – Trevor Hobday, Simone Montgomery, Nick Roberts

Rape Crisis – Karen Willis

Royal North Shore Sexual Assault Services – Jane Davidson

Stepping Out – Connie Smith

Sydney Women's Counselling – Sonya Finlayson

West Street Centre, Wollongong – Michelle Frazer; Annette Hoskins

MHCC also wish to acknowledge the many international researchers and professionals whose work has informed this Information Resource Guide and Workbook and who have kept the issue of trauma from childhood abuse at the forefront of clinical and community awareness, offering concrete material on which to develop cutting-edge evidence-based practice and policy guidelines.

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TERMINOLOGY

The term 'survivor' frequently implies either people removed in time from the original trauma or further along in the recovery process (Campbell, 2001).¹ Throughout the literature, researchers and advocates frequently use 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.

Many survivors 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 those consulted was the term 'survivor' which has been used throughout this document to reflect their preference.

This Workbook sometimes uses the term 'consumer', when referring to people engaging with mental health services.

Throughout the literature, the terms childhood abuse (CA) and child sexual abuse (CSA) are both used interchangeably. Whilst we have endeavoured to be consistent, we have used the language used in the relevant literature that is cited.

ACRONYMS

A number of acronyms have been used in this Workbook. We trust that readers will appreciate the necessity to abbreviate and will not perceive it as either 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.

Acronyms used to abbreviate organisations' names are identified where used. The following abbreviations are those used frequently throughout this Workbook:

- ABS — Australian Bureau of Statistics
- AIFS — Australian Institute of Family Studies
- AIHW — Australian Institute of Health & Welfare
- ASCA — Adults Surviving of Child Abuse
- ATSI — Aboriginal and Torres Straight Islanders
- BPD — Borderline Personality Disorder
- CALD — Culturally and Linguistically Diverse
- CA — Child Abuse
- CMO — Community Managed Organisations
- CSA — Child Sexual Abuse
- MHCC — Mental Health Coordinating Council
- MHCC LDU — Mental Health Coordinating Council Learning and Development Unit
- NESB — Non English-Speaking Background
- NGOs — Non-Government Organisations
- PTSD — Post-traumatic Stress Disorder
- SA — Sexual Assault.



SCOPE OF RESEARCH

Reframing Responses: Improving Service Provision to Women Survivors of Child Sexual Abuse who experience Mental Health Problems (which was stage one of the project) was a study focused on women survivors of childhood sexual abuse and their ability to access and equitable service delivery. Although epidemiological data confirms both genders are sexually abused, females have been shown to be at higher risk, and to date much of the research has focused primarily on women. Resources available to the project at the time did not allow MHCC to cover the issues across both genders. The lack of specific services for male adult survivors made it problematic to report definitive findings other than from data collected through the criminal justice system.

It is apparent that men present more commonly across a variety of mental health settings such as drug and alcohol services; more generalised mental health and therapeutic services and the criminal justice system. Much of the data concerning women survivors is generated from sexual assault and women's health and counselling services, and is easier to analyse and draw conclusions from.

MHCC does not wish to ignore, marginalise or minimise the issues for male survivors of childhood abuse, and much of the material in this Workbook will be useful to those working with both men and women survivors of all forms of childhood abuse, although much of the research evidence focuses on sexual abuse. However, it should be noted that men's experience of abuse and the repercussions may vary to some degree to those of women. It is necessary to be aware of the gaps in this Workbook and we alert readers of the need to clarify and address issues specific to the male experience.

The language used in stage one of the project focused particularly on women survivors of child sexual abuse. As we know from the evidence available, childhood sexual abuse rarely occurs in isolation as it is by its very nature both emotional and physical abuse simultaneously.

MHCC wish to make clear that this Workbook does not differentiate between all forms of childhood abuse: sexual; physical; and emotional including neglect as well as witnessing domestic violence, although much of the research evidence looks specifically at survivors of sexual abuse. We also know from the evidence that the impact of all forms of childhood abuse whether it is accompanied by sexual abuse or not results in similarly devastating impacts. Society is inclined to view some forms of childhood abuse as less harmful, we are keen to highlight that workers need to be aware of this and not minimise seemingly less harmful forms of abuse (Higgins, 2004).²

RESEARCH FINDINGS ^{3*}

PARTICIPANTS

For *Reframing Responses* stage one, both providers and recipients of services from community managed organisations (CMOs), (otherwise known as non-government organisations (NGOs)) were invited to participate in focus groups or individual interviews. Invitations were sent to CMOs whose focus was women.

A range of services responded to invitations to participate including: family support services; crisis services; church-based organisations that provide outreach and counselling services; women's health centres; supported accommodation services, rehabilitation services; women's counselling services and domestic violence services.

A few services responded that were providing services specifically to women survivors of childhood sexual abuse/assault (reflecting the absence of services dedicated to this group), whilst others were not specific to these clients. The size of services ranged from 2–3 staff to 15–20 staff.

The extent of disclosure of childhood sexual abuse depended on the service. Across participating services the range of childhood sexual abuse disclosed was from 25% for a non-dedicated service to 100% for a dedicated service. Even for non-dedicated services, the rate of disclosure was around 50% in a rape crisis service, and up to 90% of clients in a domestic violence service.

REFERRALS ^{4*}

Referrals to the services came from a range of sources, and included: self; mental health services; the Department of Community Services (DOCS); NGOs; other government agencies; health professionals; drug and alcohol services; Alcoholics Anonymous; police; refuge and supported accommodation services. Most services required the woman to make the initial contact herself.

It was noted that there were few referrals from general practitioners (GPs), and participants speculated that women may be unwilling to reveal a history of childhood sexual abuse to their GP or that GPs may not identify this as a problem that needs referral. Referrals to services were frequently for reasons other than childhood sexual abuse such as: depression; anxiety; substance abuse; eating disorders; relationship difficulties and gambling problems.

PRESENTING PROBLEMS ^{5*}

The initial problems that instigated referral or self-presentation included: depression; suicidality; self-harm; anxiety; substance abuse; recent sexual assault; symptoms of post traumatic stress disorder (PTSD); difficulties in relationships; domestic violence (DV) and emotional abuse; child protection issues; homelessness or danger of homelessness; and psychosis.

Providers of services identified that this group of clients presented with different problems that were complex and wide-ranging, including the effects of abuse to self that the women experienced.

It was overwhelmingly reported that survivors' core values and functioning were impacted as were their sense of self-worth and self-esteem. They experienced overwhelming feelings of shame and self-hatred, guilt and self-blame. They were harder to engage because of issues of trust and safety.

Engagement was a complex and often lengthy and problematic process requiring significant levels of skill. The client group characteristically experiences chaotic lifestyles making engagement doubly difficult.

The secrecy that surrounds childhood sexual abuse lingers, and clients often lack a sense of entitlement affecting these women's ability to identify what they need, or to ask for help.

Parenting problems are common. Emotional attachment to children may be difficult, and women may be under-or overprotective. Many women in the study were in situations of re-victimisation such as being subject to domestic violence; or having brought their matter to the courts, they were discredited by the legal system, disbelieved and ostracised by their families. Many presented with self-harming behaviours.

The timing of intervention was critical, and it was important not to give up on the client, regardless of the number of presentations. The women may have been

(9.52) There is a serious lack of capacity in the Australian mental health workforce to treat adult survivors of childhood sexual assault. Although child abuse sits at the heart of the public mental health burden, trauma and dissociation are not part of core psychiatric or psychological curriculum in Australia. As a result, the majority of mental health professionals lack the training and skills to ameliorate trauma-related mental health issues amongst children or adults.(57).

Commonwealth Senate Standing Committee on Community Affairs: Report (2008).
Towards recovery: Mental health services in Australia. Ch 9, Specific Groups.

Whilst it is encouraging that in July 2009 the NSW Government provided targeted funding to NSW Rape Crisis (in partnership with Women's Health Centres); the funding is woefully small and only enables one counsellor, one day a week to provide face to face counselling services in seven centres for adult survivors. Unfortunately, Dymrna House, one of the few well established counselling services that existed in Sydney for women survivors was unable to remain open.

Despite state and federal reviews, reports and strenuous lobbying across the mental health and community sectors, little progress has been made towards providing funding for services for adult survivors. MHCC has developed this practical Information Resource Guide and Workbook in response to the ongoing gap in service delivery to survivors of childhood abuse particularly in rural, regional and remote regions of NSW, where frequently there are no designated mental health services at all.

INTRODUCTION

Over several decades since the second wave of the feminist movement, researchers, human service providers and mental health practitioners have endeavoured to fully understand and contextualise the impact of child sexual, physical and emotional abuse on the mental and physical health of adult survivors. The literature clearly shows that childhood abuse is widespread across all socio-economic, ethnic and cultural boundaries, although statistics have proved more problematic to gather in some communities than others due to secrecy, shame, fear and isolation.

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 abuse manifest high rates of mental illness, suicidality, substance abuse and poor physical health.

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 structured barriers to access services since they often do not present in 'immediate crisis.'

Whilst the literature has been clear in this field, little has been done by governments to address the needs of survivors. Nevertheless, in 2008 a report tabled by the Commonwealth Senate Standing Committee on Community Affairs entitled: *Towards recovery: Mental health services in Australia* – specifically identified mental health issues for adult survivors of childhood abuse as an area of unmet need for consideration under COAG (Council of Australian Governments) Agreement.⁹

For many years active lobbying by the mental health sector for recognition of this group of consumers fell on deaf ears. The report is perhaps the first step towards acknowledging the gaps in service delivery that exist for survivors of childhood abuse, which were expressed as follows in the report:

(9.1) Some groups of people find it particularly hard to get the mental health care that they need. Much of the funding in the COAG Plan was for generic services. While some initiatives were targeted to particular groups, evidence to the inquiry indicates that more needs to be done to provide mental health care that meets the needs of specific groups. In this chapter the committee considers several groups of people for whom current services remain inadequate.

(9.50) Witnesses reminded the committee of the strong link between childhood sexual abuse and mental illness later in life and suggested that this is an area overdue for focus and attention. (54) The Mental Health Coordinating Council cited the findings of a 2003 report which estimated that the cost to taxpayers of child abuse and neglect in Australia was approximately \$5 billion per annum. MHCC stated:

Child abuse and neglect are the root cause of many of Australia's social ills—substance abuse; welfare dependency; homelessness; crime, relationship and family breakdown; chronic physical and mental illness. If not effectively targeted, the life-long impact of child abuse will continue unabated, putting increased pressure upon already stretched government health and social services. (55).

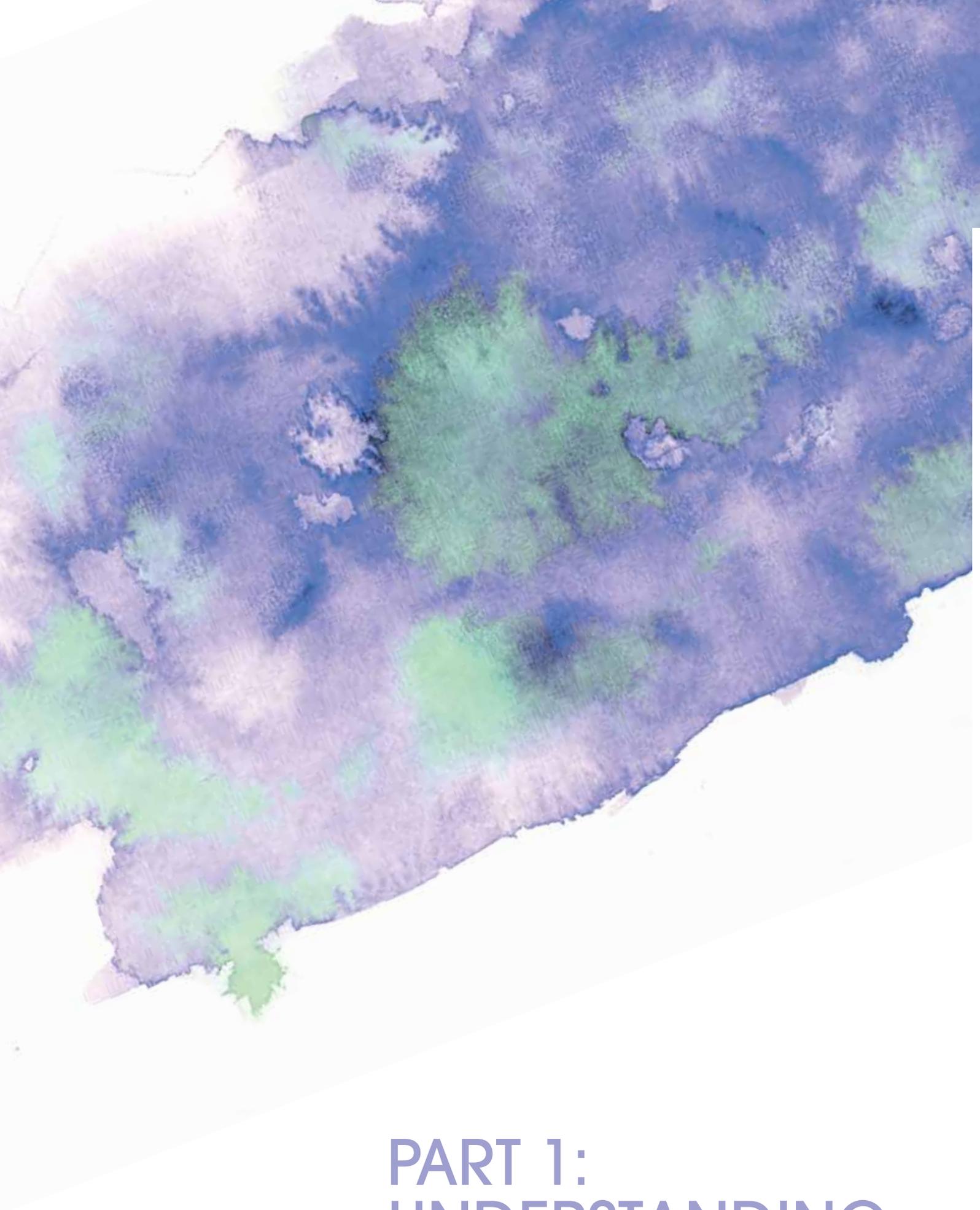
Advocates for Survivors of Child Abuse (now renamed Adults Surviving Child Abuse) commented on the severe shortages in current services:

(9.52) There is a serious lack of capacity in the Australian mental health workforce to treat adult survivors of childhood sexual assault. Although child abuse sits at the heart of the public mental health burden, trauma and dissociation are not part of core psychiatric or psychological curriculum in Australia. As a result, the majority of mental health professionals lack the training and skills to ameliorate trauma-related mental health issues amongst children or adults.(57).

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PART 1: UNDERSTANDING THE CONTEXT

CHAPTER 1

- 1.1 What is child abuse?
- 1.2 Prevalence of child abuse
- 1.3 Who are the victims of child abuse?
- 1.4 Perpetrator myths and dynamics



1.1 WHAT IS CHILD ABUSE?

According to the Australian Institute of Family Studies (AIFS, 2004):

*Child abuse is an act by parents, caregivers, other adults or older adolescents that endangers a child or young person's physical or emotional health or development. Child abuse can be a single incident, but usually takes place over time.*¹⁰

In the *Personal Safety Survey* (ABS, 2005) the definition of child physical abuse includes any deliberate physical injury (including bruises) inflicted on a child, before the age of 15, by an adult. Child sexual abuse is any act, by an adult, involving a child under the age of 15 years in sexual activity.¹¹ Workers in the sector prefer to consider any act involving a child under 18 as the appropriate definition.

Definitions of child abuse and neglect are dependent on cultural values and beliefs about appropriate childrearing and parenting, and what is considered to be an adequate standard of care can vary between, and within, communities (Korbin, 1980: 1991).¹² As a result, there is considerable disagreement as to what acts constitute child abuse.

In Australia, there is no national definition of what constitutes child abuse and neglect. Each state and territory has its own legislation and definitions; and whilst the definitions exist in legislation and for other purposes, it can be argued that in practice the process of labelling a case as one or other type of child abuse is a process of judgement and ultimately rests on value decisions.¹³

In the final analysis, all forms of childhood abuse impact negatively on the mental and physical health of victims, and no act should be minimised. *Experiencing multiple forms of abuse and neglect and the severity of the maltreatment are important factors influencing subsequent mental health outcomes* (Higgins, 2004).¹⁴

Despite problems in arriving at clear, practical definitions of the various forms of child maltreatment, it is now common practice to classify 'child abuse' according to four main types: sexual abuse, physical abuse, emotional abuse and neglect. It is important to note that children are often subjected to negative experiences from more than one of these categories (Higgins & McCabe, 2000).¹⁵

More recently a further category has been included—*witnessing domestic violence* which is often considered a form of emotional abuse. There is growing support for the experiences of children in families where there is physical and/or emotional violence between parents or with siblings (whether or not a child directly witnesses the violent acts) to be considered a distinct category of maltreatment (Parkinson, 1998).¹⁶

John Briere (1992) proposes that other forms of trauma should also be included as distinct maltreatment sub-types. These include parental alcoholism, institutional abuse, extreme poverty and homelessness. Trauma is not limited to life-threatening experiences but may be as a result of experiencing for example: separation from a mother in early childhood, living with a parent with severe depression; refugee trauma, grief and loss; or chronic stress from bullying peers at school and extreme marital stress.¹⁷

The abuse type is by no means the only factor that impacts negatively on the mental health of survivors. Factors that seem to affect outcomes are the age of the child when abused; the duration, frequency, and intrusiveness of the abuse; the degree of force used; the relationship of the abuser to the child; and most importantly, the response of carers and the system to a disclosure. Children who are pre-verbal when

abused may hold their trauma somatically without concrete memory of the abuse but experience all the negative impacts experienced by those with any degree of narrative memory.

Abused or maltreated children are often exposed to one or more harmful behaviours in the categories of abuse (Higgins & McCabe, 2000); or a series of traumatic circumstances; or serious deprivation and cruelty. The nature of the abuse and the duration of exposure to harmful behaviours and circumstances may impact on the long-term effects of the abuse into adulthood (Higgins, 2004).¹⁸

1.2 PREVALENCE OF CHILD ABUSE

WHAT DO THE AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE (AIHW) STATISTICS TELL US ABOUT THE CHARACTERISTICS OF CHILDREN WHO ARE THE SUBJECT OF REPORTS? ¹⁹

The AIHW statistics published in 2009 report that in all jurisdictions, (following notification and investigation) girls were much more likely than boys to be the subject of a substantiation of sexual abuse. In Victoria, Western Australia, South Australia and the Northern Territory, three times as many girls were subject to a substantiation of sexual abuse than boys.

The rates of substantiated abuse or neglect decreased as age increased. Children aged between 0–4 years old were the most likely to be the subject of a substantiated report of abuse or neglect, while children aged 15–16 years were the least likely.

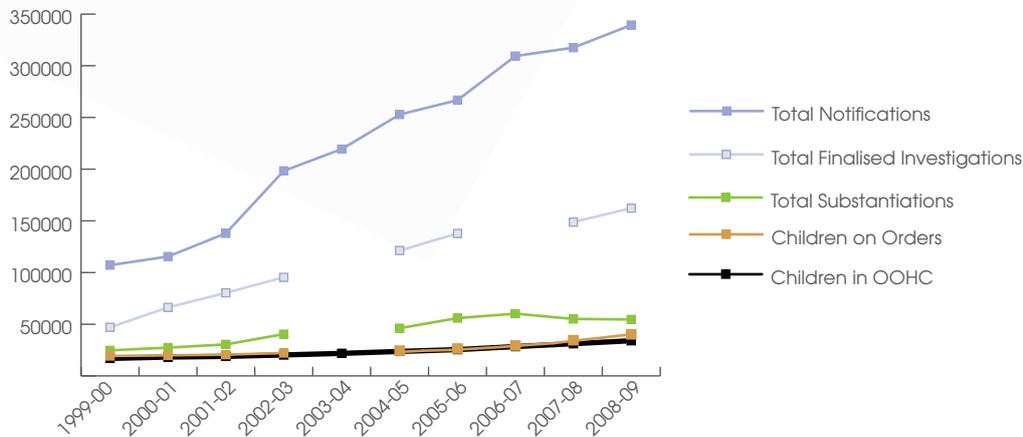
Nationally, Aboriginal and Torres Strait Islander children were more likely to be the subject of substantiated reports than were other children. Across Australia, Indigenous children were more than 6 times as likely as other children to be the subject of substantiation.

According to the ABS (2005) the proportion of women and men who experienced physical abuse before the age of 15 was 10% (779,500) and 9.4% (702,400) respectively. Women were more likely to have been sexually abused than men before the age of 15. 12% (956,600) of women reported that they had been sexually abused before the age of 15 compared of to 4.5% (337,400) of men.²⁰

HOW MANY REPORTS ARE MADE TO CHILD PROTECTION SERVICES IN AUSTRALIA EACH YEAR?

The most recent national figures from the AIHW indicate that in Australia, during 2007–08, there were 317,526 reports of suspected child abuse and neglect made to state and territory authorities. While the number of notifications increased, the increase observed was not as great as that observed between previous reporting periods. In fact, the increase observed between 2006–07 and 2007–08 is the smallest national increase recorded for total notifications over the past 10 years. Figure 1 illustrates the trends in total notifications recorded across Australia from 1998–99 to 2007–08.²¹

FIGURE 1: TOTAL NUMBER OF NOTIFICATIONS, INVESTIGATIONS AND SUBSTANTIATIONS ACROSS AUSTRALIA FROM 1998–99 TO 2007–08, AND TOTAL NUMBER OF CHILDREN ON ORDERS AND IN OUT-OF-HOME CARE AT 30 JUNE 1999 TO 2008.

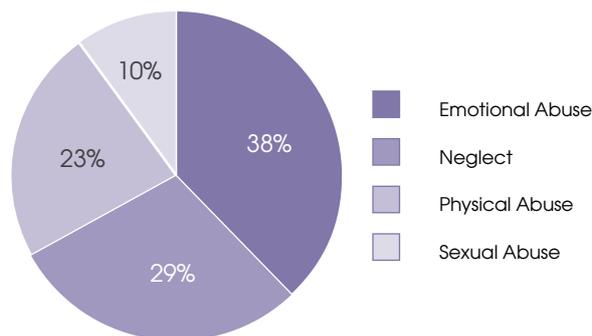


Source: Australian Institute of Health and Welfare (2009).

The maltreatment types most commonly substantiated across Australia were emotional abuse and child neglect (see Figure 2). Emotionally abusive behaviours include verbally abusing, terrorising, scape-goating, isolating, rejecting, and ignoring.

Children who witness domestic violence are also typically categorised as having experienced emotional abuse. The high proportion of substantiations of emotional abuse is a relatively new phenomenon (AIHW, 2009). The inclusion of children who have witnessed domestic violence is likely to be one of the key reasons for the high rates of substantiated emotional abuse (Holzer & Bromfield, 2008).

FIGURE 2: PERCENTAGE BREAKDOWN OF PRIMARY SUBSTANTIATED MALTREATMENT TYPES IN AUSTRALIA IN 2007–08 (SOURCE: AIHW, 2009, P. 69).



Source: Australian Institute of Health and Welfare (2009).

Neglect refers to the failure (usually by the parent) to provide for a child's basic needs, including failure to provide adequate food, shelter, clothing, supervision, hygiene or medical attention. The high rates of neglect are consistent with the disadvantaged socio-economic conditions prevalent in many families referred to child protection services (Becket, 2003).

Whilst some children who disclose may report little or no psychological distress from the abuse, these children may be either afraid to express their true emotions for a number of complex reasons or may be minimising their feelings as a coping mechanism. Other children may have what is called 'sleeper'

*effects'. They may experience no harm in the short run, but experience serious problems later in life.*²²

AIHW Australian Institute of Health and Welfare (2009).
Child abuse and neglect statistics. AIFS National Child Protection Clearinghouse

1.3 WHO ARE THE VICTIMS OF CHILD ABUSE?

Conservative estimates indicate that one in five girls and one in seven boys experience some form of sexual abuse before reaching adulthood (Dunne, Purdie, Cook, Boyle, & Najman, 2003).²³ According to ABS statistics in Australia one in eight women and one in twenty two men are sexually abused before the age of 15, although there is strong evidence that figures are much higher due to unreported or uncorroborated evidence.²⁴ Evidence in the USA has identified that one in three girls and one in six boys are sexually abused before the age of eighteen.²⁵

Children and adolescents, regardless of their race, culture, or economic status, appear to be at approximately equal risk for sexual victimisation. Statistics show that girls are sexually abused more often than boys. However, therapists working with boys and men report that males tend not to report victimisation which may affect statistics. This may be because they blame themselves; minimise the abuse; are ashamed that they were unable to defend themselves or in some way relate the abuse to either real or feared homosexuality, and they fear stigma and discrimination.²⁶

A report found that whilst girls were about three times more likely to be the subject of a substantiated sexual abuse claim, they are equally likely to be the subject of a substantiated claim of physical abuse. Boys are more likely to be physically than sexually abused. In addition, the rates of substantiated abuse or neglect decreased as age increased (AIFS, 2008).²⁷

Mandatory reporting laws, although different in each state in Australia, were introduced in response to the growing awareness around child abuse, to protect children from further abuse (Higgins, Bromfield, & Richardson, 2006).²⁸

These laws mandate professionals working with children to report any child they suspect of being in danger of abuse. In spite of these mandatory reporting laws, statistics suggest that child abuse remains prevalent.²⁹

In a six-month telephone survey of 6,677 women conducted over a period during 2002–03, data provided 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. Of the participants interviewed 18% reported that they had been sexually abused before age sixteen (AIFS, 2003).³⁰

The NSW crime statistics for the March quarter 2005, record sexual assault figures for the year at 4,134 and other sexual offences at 5,386.³¹ These figures fail to identify child sexual abuse 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. However, numerous studies have identified that 39% of adult sexual assault (SA) survivors have experienced other or multiple assaults.³²

The National Association of Services against Sexual Violence (NASASV) in a *Snapshot Data Collection by Australian Services against Sexual Violence: June 2000*, recorded service user characteristics in fifty-one participating services over a three-week

period. According to the report, 62% of service users were survivors. The largest single category numbering more than 50% represented contacts related to sexual abuse during childhood.³³

A study conducted by Palmer, Brown, Rae-Grant and Loughin (2001) identified that most survivors of any abuse reported a combination of abuse types:

- physical, emotional and sexual (45%)
- physical and emotional (21%)
- sexual and emotional (17%)
- sexual only (11%) and
- emotional only (6%).

Of the survivors in the study who could recall the age of onset of the abuse, they reported that they had been very young (between 4 and 6) and that the reported perpetrators were:

- biological fathers (34%)
- biological mothers (19%)
- stepfathers, adoptive fathers and foster fathers (8%)
- stepmothers, adoptive mothers and foster mothers (5%)
- both parents equally (7%)
- other relative (14%)
- and siblings (10%).³⁴

Re-victimisation is also a common phenomenon among people abused as children. Research has shown that child sexual abuse victims are more likely to be the victims of rape or to be involved in physically abusive relationships as adults.³⁵

Whilst 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.

WOMEN WITH DISABILITIES

During the conference, *'Home Truths: Stop Sexual Assault and Domestic Violence – A National Challenge,'* Women with Disabilities Australia (WWDA) identified women with disabilities as one of the most *'marginalised'* groups experiencing discrimination. International studies (highlighting the paucity of research in Australia) indicate that 90% of women with intellectual disabilities have been sexually abused, mostly before the age of eighteen (2004).³⁶ Wilson and Brewer (1992) also found that women with an intellectual disability were more than 10 times as likely to be assaulted as other women.

There is a dearth of research in Australia about the relationship between gender, violence and disability. Traditionally, much of the literature on violence against women with disabilities has tended to focus particularly on sexual abuse and mainly in relation to people with intellectual disabilities (McCarthy, 1996; Sobsey & Doe, 1991).³⁷

Overseas studies have found that women with disabilities, regardless of age, race, ethnicity, sexual orientation or class are assaulted, raped and abused at a rate of at least two times greater than non-disabled women (Sobsey, 1988, 1994; Cusitar, 1994; Stimpson & Best, 1991; Dawn, 1988). Sobsey (1988) suggests that 83% of women with disabilities will be sexually assaulted in their lifetime and a Canadian qualitative study by Nosek (1996) found approximately one third of women with physical disability had experienced sexual abuse at some stage in their life.³⁸

CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) WOMEN

Studies on the prevalence of violence against CALD women whether perpetrated as children or adults are scarce and non-existent for men. 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).³⁹

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 contribute to a reluctance to report childhood abuse or current violence (Ouzos & MacKay, (2004).⁴⁰

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*.⁴¹

This refers to cultural norms regarding issues such as: the position of women from NESB cultures and religious beliefs to men in their community; issues surrounding marriage and virginity; their dependence on same culture medical and other service delivery agents; fear of confidentiality, retribution, stigma and parenting issues.

Community services experience ongoing difficulties in engaging bilingual workers who can provide culturally appropriate services and who understand childhood abuse and CSA-related issues within a cultural context. This aspect is particularly problematic in small or isolated communities with little access to any support services, particularly in rural areas.

*The difficulties for women from NESB backgrounds in accessing appropriate and adequately resourced services have remained almost unchanged over the past decade.*⁴²

Keel, M., Fergus, L. & Heenan, M. (2005). *Home Truths: A Conference in Review*. ACSSA Issues (3) March 2005.

ABUSE IN INDIGENOUS COMMUNITIES

The contexts in which Indigenous children experience abuse are 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-existing alcohol and other drugs in Indigenous survivors of CA and CSA. Other considerations are the disabling factors of generational social disadvantage.⁴³

CSA particularly is now being reported at high levels in Indigenous communities across Australia. The report *From Shame to Pride* provided a detailed account of CSA amongst Indigenous communities. The problem was found to be widespread and endemic (2004).⁴⁴ Even these statistics, however, are believed to be drastically underestimated. A submission to the Gordon Inquiry from the WA Police Service ('WAPS') suggests a level of reluctance within the Aboriginal communities studied to report cases of CSA. WAPS reported that only 10 to 15 per cent of all sexual assaults are reported to the police and that this rate is far lower in Indigenous communities (2004).⁴⁵

The Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse was established on 8 August 2006 and reported in June 2007. The Inquiry sought to find better ways to protect Aboriginal children from sexual abuse. In 2007, the Howard Government sought to vigorously intervene in addressing issues of child abuse in Aboriginal communities in the Northern Territory, which was widely

Part 1: Understanding the Context

welcomed. In announcing the measures that the government would take to deal with child sexual abuse, the Prime Minister drew attention to the comprehensive report into child sexual abuse in the NT by Pat Anderson and Rex Wild entitled: *Little children are sacred*. However, the government's response was in direct contrast to the recommendations of this report,⁴⁶ in both content and philosophy.⁴⁷

The government measures involved considerable reliance on uniformed services and coercive interventions, and limited consultation with the Aboriginal communities and leaders concerned. Evidence for the effectiveness of some of the strategies does not appear to exist; nor does this seem to have been a dominant consideration.

There was some considerable disquiet amongst Aboriginal people and others who consider that there was an underlying agenda to the way in which the research had been conducted, and that it focused only on Aboriginal communities at risk, failing to deal with the issues of poverty, unemployment and health issues endemic in these communities as well as looking at other communities with equally concerning child abuse related issues. Unfortunately, we have not way of confirming the truth of any assertions with regards to the research or the intervention, but nonetheless flag it as a matter of concern.⁴⁸

The extent and type of child abuse and neglect in Indigenous communities which was notified (or reported) to child protection departments around Australia in 2001–02, identified that 3,254 Indigenous children under 17 years had some form of abuse substantiated (i.e. the statutory protection authority believed that physical abuse, psychological abuse, sexual abuse and/or neglect, had occurred). This rate of substantiation was disproportionately higher (4.3 times higher on average) in the Indigenous population, than in the non-Indigenous population. Substantiation varied across states, from two Indigenous children in Tasmania to a rate of nearly eight times higher for Indigenous children in Victoria and Western Australia (2007).⁴⁹

Shame plays a major role in the failure to disclose CSA in all communities. However, particular to Indigenous communities (which characteristically are environments where people have strong interfamilial connections in small communities) disgrace, dishonour, humiliation and powerlessness of victims, extended family, community loyalty, and abuse of power by authority figures has led to significant under-reporting of CSA. The extent of CSA in Indigenous communities may even not be recognised as it should be, partly because of a failure to report, and respond, to many assaults.

Failure to report is also as a consequence of a fear of racism; fear of the police response; reprisal from the perpetrator in small, closed communities; pay-back from relatives; or a perceived need to protect the perpetrator due to reasons such as the high number of Indigenous deaths in custody. Fitzgerald (2001) writes that this is a realistic fear, particularly in Cape York communities where a death in custody would be seen as the fault of the person who reported the abuse (usually the adult female survivor or caregiver of a child).

There are also difficulties in communicating with legal staff. It is difficult for some Indigenous people to translate their experience into terminology required for legal processes; or an absence of someone to report to in remote communities. In fact there may be no means of reporting in remote communities where poverty, isolation and the relatively small size of the community means there is no public transport and no private vehicles to provide access to support and secure shelter; and there is an endemic lack of trust of the 'white man's' system.⁵⁰

In early 1991, a report of the Royal Commission into Aboriginal Deaths in Custody was presented to Federal Parliament. The Royal Commission had been established to investigate why a large number of Indigenous people had died in police custody or in prison. The report found that Indigenous Australians were between 7 and 22 times more likely to die in custody than non-Indigenous Australians. Indigenous adults

were 13 times more likely than other Australians to be in prison in 2008. In 2000 this figure stood at 10 times. Young Indigenous people are 28 times more likely to be detained in juvenile detention. Whilst reports show a high proportion of Aboriginal deaths in custody, this is in proportion to the high numbers of Indigenous people in the prison system.⁵¹

Dudgeon et al., (1993)⁵² and Garvey (2000)⁵³ reported that Indigenous people do not access mental health services at a level commensurate with need (AIHW, 2002:2003).⁵⁴ Those Indigenous people who do make contact with mental health services are more likely to receive services which are reactive in nature. Indigenous people express concerns at being labelled and stereotyped, misjudged or misunderstood, or not presenting in a way that was seen as 'correct' (Atkinson & Clarke, 1997, Mammoth, Stacy, Chambers & Keys, 2000, Clark et al., 2000).^{55 56}

Whilst there have been considerable moves towards improving access for Indigenous people to culturally appropriate mental health services, frequently workers are insufficiently trained and skilled in articulating mental health in culturally accepted ways.

There have been initiatives established to train Indigenous people to work within their own communities in mental health by providing scholarships, but take up numbers have been disappointing. Contributing to the problem of inequity of access to mental health services by Indigenous people, is the lack of appropriate services for adult survivors of childhood abuse experiencing mental health problems, particularly in rural, regional and remote areas.

Whilst non-Indigenous 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).⁵⁷

Identifying successful outcomes attributable to model of service delivery or intervention is problematic, due to a lack of research evidence quantifying outcomes from a culturally appropriate perspective.

LESBIAN WOMEN

The prevalence of alcohol, tobacco and illicit drug use has been reported to be higher among lesbian and bisexual women (LBW) than their heterosexual counterparts.⁵⁸ However, few studies have been conducted with this population in Australia and rates that have been reported vary considerably.⁵⁹ A number of theories have been advanced to explain high rates of drug use in this population which relate to how gay, lesbian and bisexual (GLB) populations choose to socialise.⁶⁰

Precise estimates of the prevalence of drug use amongst LBW have proved difficult to ascertain. Previous studies have been hampered by small sample sizes, the use of convenience samples obtained in bars and nightclubs, and a focus on urban populations.⁶¹ In addition, population-based surveillance systems have often failed to collect information regarding sexual orientation, limiting the ability to make comparisons between heterosexual and GLB populations.^{62 63}

Several studies in the USA concluded that lesbians are more likely to have been sexually abused as children.⁶⁴ There is little evidence available in Australia. In 1999, Roberts and Sorenson published a survey of 418 women in Chicago in which 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. Twice as many lesbians reported sexual abuse before the age of fifteen, compared to heterosexual women. Of all the lesbians surveyed 29% reported sexual abuse, black lesbians reporting higher rates of abuse than the white lesbians in the study.⁶⁵

1.4 PERPETRATOR MYTHS AND DYNAMICS

WHO ARE THE PERPETRATORS OF CHILD SEXUAL ABUSE?

It is clear from the available evidence that children are most likely to be physically or emotionally abused, or neglected, by parents or other primary caregivers as well as people in loco parentis with responsibility and access to children in the community (Cawson et al., 2000). Despite the general view that children are sexually abused mainly by strangers, the reality is that most sexual abuse is perpetrated by someone who is known to the child, such as a family member, family friend or person with whom the child comes into contact (e.g., sports coach, teacher, priest) (Leventhal, 1998).⁶⁶

In a review of North American sexual abuse prevalence studies, Finkelhor (1994) found that sexual abuse is committed primarily by males (90 per cent of cases).⁶⁷ The review also found that the child knew most perpetrators although 'strangers' constituted between 10–30% of offenders. Non-biological male family members (stepfather or mother's de facto partner) are disproportionately represented as sex offenders. For example, Russell (1989) reported that girls living with stepfathers were at a markedly increased risk: 17% had been sexually abused compared with 2.3% of girls living with biological fathers.⁶⁸

Whilst research shows men to be the perpetrators in most instances of sexual abuse, there is growing evidence of cases in which women are the offenders. In a review of the evidence for female sex abusers, Finkelhor and Russell (1984) concluded that females do abuse in a small proportion of cases: approximately 5 per cent of female victims, and 20 per cent of males victims experience sexual abuse perpetrated by a female.⁶⁹ Information about women who sexually abuse is extremely limited, partly because of a lack of survivors' accounts that exists, unlike the accounts of those abused by men. Published accounts of sexual abuse by women include: *When you're ready* (Evert & Bijkerk, 1987) and *Ordinary Wonders* (Green, 1992).⁷⁰

Finkelhor and Russell (1984) estimated that 5 per cent of sexual abuse of girls and 20 per cent of abuse of boys is perpetrated by women. A section of the 1990 report of the British National Society for the Prevention of Cruelty to Children (NSPCC) stated clearly that their figures did not support the theory that women abusers were merely the 'tip of the iceberg' in terms of offending. In 1991, the Adelaide Children's Hospital estimated that ten per cent of the child clients had been sexually abused by a woman (Crisp, 1991).⁷¹

In 1998, Fitzroy suggested that there was: *need to incorporate information on domestic violence and child abuse in a more critical manner that addresses the impact of cultures of violence on women's choices to enact violence against their children.*⁷²

Over the last decade there has been greater analysis surrounding gender and power; mothering and ambivalence; and the impact of childhood experiences, class and culture on women's access to power and chances to enact violence.⁷³

There is no evidence to suggest that homosexual men are more likely to sexually abuse children than heterosexual men. This is a common myth fuelled by ignorance and homophobia.

It is widely believed that children who have been maltreated are more likely to become abusive parents than children who have not been maltreated. When this occurs this is known as the intergenerational transmission of abuse. Current evidence suggests that the: *majority of parents who have been maltreated as children do not become abusive or neglectful parents* (Tomison, 1996b).⁷⁴

The best estimates are that approximately 30 per cent of maltreated children (plus/minus 5 per cent error) will go on to maltreat children in some way when they are adults (Kaufman & Zigler, 1987). This figure needs to be approached with caution because of methodological issues.⁷⁵

Research indicates that family violence and child maltreatment co-occur. However there are few studies that investigate the number of children exposed to family violence and the identity of the perpetrators of the violence to which children are exposed (Tomison & Tucci, 1997).⁷⁶ However, the 1996 Women's Safety Survey (ABS, 1996) showed that men in cohabiting relationships were about twice as likely as married men to perpetrate emotional and physical violence toward their current partner.⁷⁷

CHILDREN WHO ABUSE OTHER CHILDREN

Research has now shown that children and young people perpetrate up to one third of all sexual abuse against other children. Nonetheless, young people are engaging in consensual peer-related sexual experimentation and activities at younger ages than many realise. Furthermore, in some immigrant communities the age of marriage is comparatively young—fourteen and fifteen-year-olds may be married and become parents. The interface between mainstream Australian law and accepted cultural practices of minority groups is frequently marked by confusion and ambiguity.⁷⁸

While the literature on adolescent sexual offending has expanded in recent years, there remains comparatively less literature with a focus on adolescent sibling incest. However, there is growing evidence that sibling incest is more common than parent-to-child incest. For example, Bentovim et al., (1991) reported that 90% of intra-familial abuse occurs between people from the same generation.

In a study on intra-familial adolescent sex offenders, Grant et al., (2009) found that offenders are highly likely to be victims of sexual and/or physical abuse within the family; have a large number of co-occurring psychological, social, and family problems; and are a heterogeneous group with different personality factors contributing to the offending.⁷⁹

Estimating the prevalence of intra-familial sexual abuse is a difficult task given the secrecy surrounding CSA. It is widely acknowledged that reported cases of CSA are but a small proportion of the real incidence rate (Nisbet, 2000). It has also been suggested that between 30–50 per cent of these sexual offences are committed by adolescent perpetrators (Ryan & Lane, 1997). Furthermore, it is estimated that 40 per cent of abuse is committed by an adolescent, biological relative (Ryan et al., 1996), with sibling incest suggested to be three to five times more prevalent than father-daughter incest (Cole, 1982).⁸⁰

*At the very outset research in this area is challenged to distinguish sexual behaviours between children/adolescents that may be experimental and that which is abusive. The question of what behaviour constitutes "abuse" is vital so that we can separate non harmful sexual experimentation from damaging victimisation. In the current research the emphasis is on harmful, exploitative, and abusive behaviour sometimes defined as involving a developmental age difference between the abuser and the victim.*⁸¹

Grant, J., Indermaur, D., Thornton, J., Stevens, G., Chamarette, C. & Halse, C. (2009). *Intrafamilial adolescent sex offenders: psychological factors and treatment issues.*

The Victorian Community Council against Violence (VCCAV) ran an 18-month project that aimed to develop recommendations toward a whole of system response to these young offenders (Broughton, 2001).⁸²

MYTHOLOGY ABOUT CHILD SEX OFFENDING

In the research study conducted by the Research and Education Unit on Gendered Violence (University of South Australia) entitled: *Moment by Moment...I Coped: South Australian Women on the Subject of Childhood Sexual Abuse* (2005).⁸³ Glaser (1997) describes intra familial child sex offenders as *...simply a paedophile who sometimes abuses his own children or young relatives.*⁸⁴

The research paper also refers to a comprehensive review of the international literature by Freer and Seymour (2002)⁸⁵ which details the ways in which offenders move between the family and the community, identifying the overlap between intra-familial sex offending or incest and extra familial sex offending or paedophilia (Itzin, 2001).⁸⁶ Itzen has identified previous research that supports the findings of the South Australia research project, that men who sexually abuse their own children may also abuse children outside of the family home and that these same men will often involve their children in prostitution and child pornography. They suggest that: *this has implications for police investigations and social service interventions which often focus narrowly on expectations of sex offender behaviour.*⁸⁷

*Conceptualised as separate, there is a presumption that incest abusers and paedophile abusers are not the same people, and the impression is created that paedophiles are not fathers who commit incest, and that fathers who commit incest only victimise their own children and are not then conceptualised as paedophiles who may abuse other people's children.*⁸⁸

Itzen, C. (2001). *Incest, Paedophilia, Pornography and Prostitution: Making Familial Males Visible as the Abuser.* Child Abuse Review 10:37.

This unfortunate view of child sex offending may certainly prevent authorities from considering the children in the home of a paedophile, as several survivors in the South Australia study reported.⁸⁹ A survivor in the study recalled that whilst her father was convicted for her sexual abuse he was given weekend prison detention and remained living in the family home during the week. When she reported this (in 1986) to a social worker she ended up in foster care, rather than her father being removed from the home where her mother and siblings lived.⁹⁰

INCEST

Incest traditionally describes sexual abuse in which the perpetrator and victim are related by blood. However, incest can also refer to cases where the perpetrator and victim are emotionally connected, such as a step-parent (Crnich & Crnich, 1992).⁹¹ Intra-familial perpetrators constitute from one-third to one-half of all perpetrators against girls and only about one-tenth to one-fifth of all perpetrators against boys.

*There is no question that intra-family abuse is more likely to go on over a longer period of time and in some of its forms, particularly parent-child abuse, has been shown to have more serious consequences.*⁹²

Finkelhor, D. (1994). *Current Information on the Scope and Nature of Child Sexual Abuse.* The Future of Children, 4(2): 31, 46-48.

CHAPTER 2:

- 2.1 Impact of childhood abuse
- 2.2 Psychological consequences
- 2.3 Physical health consequences
- 2.4 Other consequences
- 2.5 Cost to the community



2.1 IMPACT OF CHILDHOOD ABUSE

WHAT ARE THE IMPACTS OF CHILDHOOD ABUSE ON THE INDIVIDUAL?

Some early studies between the 1950s and 1970s such as the famous Kinsey Report, *Sexual Behaviour in the Human Female*, suggested that: *sexual abuse could contribute favourably to psychosexual development or that sexual abuse did not necessarily or inevitably have a detrimental effect.*⁹³ Such conclusions served only to minimise the seriousness of the prevalence of abuse and delay both clinical and community understanding of the needs of victims both psychologically and legally.

Other research at the time identified factors such as personal strength and resourcefulness, or the presence of a supportive relationship with a parent or other adult that may help to prevent traumatisation.⁹⁴

Subsequent research over the past forty years (evidenced in the wealth of research supporting this workbook) concluded that almost without exception, the impact of childhood sexual (and indeed all forms of) abuse is harmful, although personal resilience and the presence of a supportive relationship can ameliorate some impacts (see 3.4: Resilience).⁹⁵

The impact of child abuse and neglect is often discussed in terms of physical, psychological, behavioural, and societal consequences. They are impossible to separate completely. Physical consequences, such as damage to a child's growing brain, can have psychological implications such as cognitive delays or emotional difficulties. Psychological problems often manifest as self-harming behaviours and the negative effects of all forms of childhood abuse can affect the victim for many years and into adulthood.⁹⁶

Depression and anxiety, for example, may make a person more likely to smoke, abuse or misuse alcohol or illicit drugs, or overeat. High-risk behaviours, in turn, can lead to long-term physical health problems such as sexually transmitted diseases, cancer, and obesity. The cost to the individual of child abuse over a lifetime is incalculable.

Children and adolescents who have been sexually abused can suffer a range of psychological and behavioural problems, from mild to severe, in both the short and long term. These problems typically include depression, anxiety, guilt, fear, sexual dysfunction, withdrawal, and acting out. Depending on the severity of the incident, victims of sexual abuse may also develop fear and anxiety regarding the opposite sex or sexual issues and may display inappropriate sexual behaviour. However, the strongest indication that a child has been sexually abused is inappropriate sexual knowledge, sexual interest, and sexual acting out.

The initial or short-term effects of CSA usually occur within two years of the ending of the abuse. These effects vary depending upon the circumstances of the abuse and the child's developmental stage but may include regressive behaviours (such as a return to thumb-sucking or bed-wetting), sleep disturbances, eating problems, behaviour and/or performance problems at school, and non-participation in school and social activities.

Childhood sexual abuse often fosters the conditions for the development of mental illness, particularly depression and anxiety disorders. The most frequent symptom 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. Characteristically, survivors of childhood sexual abuse are different to other depressives, exhibiting

early onset and a tendency towards chronicity, lowered self-esteem and sense of hopelessness (Henderson & Brown, 1988; Harris, 1988; Romans et al., 1992).⁹⁷

High levels of anxiety in these adults can result in self-medicating behaviours, such as alcoholism or drug abuse, as well as anxiety attacks, situation-specific anxiety disorders, and insomnia. Many victims also encounter problems in their adult relationships and in their adult sexual functioning.

Numerous studies have examined the association between a history of all forms of child abuse and subsequent mental illness in adult life. There is an established body of knowledge clearly linking all forms of abuse with higher rates of substance abuse disorders, eating disorders and Post-traumatic Stress Disorders in adults.⁹⁸ A more controversial study links multiple personality disorder with childhood sexual abuse.⁹⁹ In short, the ill effects of child abuse are wide-ranging. There is no one set of symptoms or outcomes that victims experience.

The precise psychological impact of abuse differs as a result of a number of variables. This may include one or more variables, such as: disposition; resilience; bio-psychological factors; family environment, security; positive parent/child attachment, and previous history of support or abuse. In addition, it appears that the type of child abuse is, to some extent, related to the form of subsequent psychological distress or disorder.¹⁰⁰

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 Post Traumatic Stress Disorder (PTSD) features amongst the variety of negative mental health effects of childhood abuse, a view supported by workers in the field.¹⁰¹

Clinicians and researchers have suggested that a diagnosis of PTSD does not adequately reflect the severe psychological harm that occurs as a result of the protracted, repeated trauma frequently experienced by survivors of child sexual abuse (Cozolino, 2002).¹⁰²

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 another diagnosis, Complex PTSD (CPTSD) to describe the symptoms of long-term trauma, particularly applicable to survivors of child sexual abuse.¹⁰³

Himelien and McElrath (1996) examined cognitive coping strategies associated with resilience in child sexual abuse survivors. In this study, women completed surveys assessing self-enhancing cognitive distortions of reality, known as positive illusions in relation to a history of child sexual abuse. Child sexual abuse survivors and non-victimised women were found to be equally likely to engage in illusion, and for both groups, measures of illusion were strongly associated with psychological well-being.¹⁰⁴

Survivors participating in this study were interviewed regarding their efforts to cope with the abuse. Analysis was focused on comparisons between women who appeared less damaged by their experience than those presenting with complex mental health problems. The high adjustment group revealed a greater tendency to engage in four types of cognitive strategies: disclosing and discussing child sexual abuse, minimisation, positive reframing, and refusing to dwell on the experience. The results of both studies highlight the importance of cognitive reappraisal in recovery. Implications for people working with child sexual abuse survivors are clear in terms of utilising strength-based models (Himelein & McElrath, 1996).¹⁰⁵

SILENCE

A critical event in terms of the effect on a child is the way that the initial disclosure is received.¹⁰⁶ The immediate responses to a disclosure, whether made to a family member or person in authority such as a school principal or church leader, may include horror, disbelief, denial, blame, punishment, rejection, or failure to intervene at all, or any combination thereof. Acceptance and validation are critical, otherwise the problem can be driven underground and the victim left severely harmed.¹⁰⁷

Distressed parents can easily and unwittingly question the child in a way that can be very traumatising making them the centre of attention because of an allegation of sexual abuse.¹⁰⁸ Conversely, children may be silenced and isolated in order to avoid embarrassment and shame for the family.¹⁰⁹ The parent or caregiver who communicates disbelief of an allegation to a child, even indirectly and in subtle ways, can cause the child to accept the denial in order to maintain their attachment to the parent.¹¹⁰ A person in authority who responds similarly may cause the child to lose all faith in the justice of his or her claim.

The research study *Moment by Moment...I Coped: South Australian Women on the Subject of Child Sexual Abuse* (2005) described in detail how difficult it is for children to speak about sexual abuse and how willingly adults collude in the silence and secrecy.¹¹¹ Frequently disclosure resulted in significant personal harm for the participants and their non-offending mothers.

Workers need to be aware of the enormity of disclosure and the associated fear that disclosure brings. Perpetrators exploit the fact that children believe what they are told. This might include threats of violence to the child or others that 'telling' would get them into trouble, and that they would not be believed if they did tell. Perpetrators use their position of power and influence to confuse and manipulate a child's reality.

For survivors who did disclose to parents, counsellors and GPs, many either did not believe them or minimised the abuse, for example if penetration could not be established. Others spoke of 'experts' who advised that speaking about their abuse would delay their getting on with life. Many survivors talked about their abusive partners using knowledge of their childhood abuse to re-victimise them.¹¹²

2.2 PSYCHOLOGICAL CONSEQUENCES

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 child sexual abuse (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).¹¹³

Unresolved trauma which often results in 'information-processing' deficits that disrupt integrated neural processing is frequently predictive of later development of PTSD, and the disruption of interpersonal bonding and bodily regulation processes (Henry et al., 1984).¹¹⁴

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.

"The great thing about dissociation is that it keeps me safe. I'm up there looking down..... as though I am watching someone else."

An increased likelihood of PTSD symptoms observed in a medical setting with certain types of procedures such as pelvic examinations 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 (Robohm & Bутtenheim, 1996).¹¹⁵

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.¹¹⁶

Adults Surviving Child Abuse (ASCA) identify dental procedures as a trigger for memories of oral rape.¹¹⁷ Survivors anticipating such reactions may avoid required medical interventions further increasing risk to physical health.

DISSOCIATION

Dissociation is usually triggered by a strong emotional reaction such as feelings of terror, surprise, shame, helplessness, or feeling trapped or exposed.¹¹⁸

*Dissociation is an unconsciously determined ego defence involving a disruption in the normal interconnection between memory, emotion, and self-awareness.*¹¹⁹

Nurcombe, B. (2005). Paper Presented at Ausinet Workshop. Brisbane.

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 Identity Disorder (DID) is a psychiatric diagnosis describing a condition in which a person displays multiple distinct identities or personalities (known as alter egos or alters), each with its own pattern of perceiving and interacting with the environment.

Dissociative symptoms have been found in adults with a history of CSA.¹²⁰ 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.¹²¹

BORDERLINE PERSONALITY DISORDER

Borderline personality disorder (BPD) is the name given to one of a group of psychiatric conditions called 'personality disorders' characterised by distressing emotional states; difficulty in empathising and relating to other people; aggression; poor impulse control and self-harming behaviours such as substance abuse, eating disorders, cutting and self mutilation. Some researchers have estimated that up to 75% of individuals with BPD have experienced some degree of sexual abuse in childhood (Linehan, 1993).¹²²

The causal relationship between BPD and CSA subject to reservations concerning the reliability of a BPD diagnosis and the frequent co-occurrence of child sexual abuse; neglect; physical abuse; emotional abuse and exposure to domestic chaos in families of those diagnosed (Nurcombe, 2005; Barnard et al., 1985).^{123 234}

Cozolino (2005) and Herman et al., (1989) suggest that BPD may be one variant of Complex PTSD, citing widespread evidence of early abuse, trauma and the presence of dissociative symptoms (p.31).^{125 126}

SUBSTANCE ABUSE AND MISUSE

Childhood abuse has long been associated with increased risk of alcohol related problems. Studies report higher rates of both physical and sexual abuse among alcohol abusers than in general population samples (Brems et al., 2004; Clark et al., 1997; Langeland and Hartgers, 1998; Dube et al., 2002; Fergusson and Lynskey, 1997; Galaif et al., 2001; Miller and Downs, 1995; Nelson et al., 2002; Wilsnack et al., 1997b).¹²⁷

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 who had a history of sexual abuse.¹²⁸

However, conflicting results on the possible relationship between childhood abuse 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.

*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.*¹²⁹

Fleming, J., Mullen, P.E., Sibthorpe, B., & Bammer, G. (2006). *The long-term impact of child sexual abuse in Australian women*. Australia: Child Abuse and Neglect.

Evidence exists of the protective effects of a caring, supportive mother, which may limit some of the potentially adverse effects of abuse on subsequent susceptibility to alcohol abuse.¹³⁰

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 developmental age, abuse, family and social experiences, and the emergence of problems in adulthood.¹³¹

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.*¹³²

Johnson, H. (2004). *Drugs and crime: a study of incarcerated female offenders*. Research and Public Policy Series No 63. Canberra: Australian Institute of Criminology.

SUICIDALITY, SELF-INJURY AND DAMAGING LIFESTYLES

Suicidality has been associated with childhood abuse in a number of studies.¹³³ In one, 16% of survivors had attempted suicide compared to 6% of their non-abused cohorts.¹³⁴

Self-injury is consistently described among survivors (Lindberg et al., 1995).¹³⁵ In one study, 70% of survivors with a history of child sexual abuse who suffered from anorexia or bulimia had self-harmed by overdosing, poisoning, cutting or burning themselves or by head-banging.¹³⁶

Indiscriminate sexual behaviour and sexual promiscuity have also been described as one of the consequences of sexual abuse,¹³⁷ as is an increased risk of unintended pregnancy and sexually transmitted disease.^{138 139}

Browne and Finkelhor (1986) identify prostitution as sequelae to child sexual abuse and refer to existing research as finding a 46% prevalence of child sexual abuse among a sample of prostitutes (whilst not matching them against a comparison group of non-prostitutes).¹⁴⁰

Child sexual abuse has also been associated with running away from home in adolescence and female adolescent delinquency, both of which can be linked to prostitution.¹⁴¹ Extensive research suggests that many adult and adolescent prostitutes are reported to relate their choice of profession to childhood abuse (Bagley & Young, 1987).¹⁴²

Easteal (1994) found that 80–85% of women in Australian gaols have been victims of incest or other forms of abuse.¹⁴³ 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.¹⁴⁴

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.¹⁴⁵

EATING AND ANXIETY DISORDERS

Eating disorders, particularly bingeing and purging, have been linked to childhood sexual abuse and PTSD.¹⁴⁶ Individual risk factors for eating disorders include: female gender; genetic vulnerability; family history of psychiatric disorder; pre-morbid obesity; a perfectionist or somewhat obsessional 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 (Nurcome, 2005).¹⁴⁷

Much of the 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.*¹⁴⁸

Lederman, G. (2004). *Anxiety and Eating: The Relationship between Anxiety Disorders and Eating Disorders*. The Reporter: Anxiety Association of America.

It is unclear whether the eating disorder results from the heightened level of anxiety associated with PTSD. According to Timothy Brewerton, (2004) Managing Director 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*, the act of purging has a numbing effect and many bulimics report that they feel more relaxed and less anxious after purging.¹⁴⁹

2.3 PHYSICAL HEALTH CONSEQUENCES

IMPACT OF CHILD SEXUAL ABUSE ON PHYSICAL HEALTH

Although childhood sexual abuse is associated with a wide range of health problems later in life, there is evidence of substantial individual differences. A study in 2007 describes the mental and physical health of a population sample of male and female Australians, randomly selected from the Commonwealth electoral roll, who have reported their childhood sexual abuse histories (Najman et al., 2007).¹⁵⁰

Men who had experienced non-penetrative and penetrative sexual abuse in childhood had 2.25 times the rate of impaired mental health, but no higher rates of impaired physical health. Women who had experienced non-penetrative and penetrative sexual abuse in childhood had 1.87 and 3.15 times respectively the rate of impaired mental health and 1.87 and 2.31 times respectively the rate of impaired physical health.¹⁵¹

The Illinois Coalition against Sexual Assault (CASA)¹⁵² reporting on the long term consequences of child sexual abuse 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.¹⁵³

Gastrointestinal (GI) problems may be second only to depression as the most frequent long term consequence of CSA. Golding (1994) found that as many as 71% of adolescent girls and adult women, who experience sexual abuse for more than two years may later develop GI disorders.¹⁵⁴ Another common complaint is irritable bowel syndrome, as is chronic abdominal pain. According to Drossman (1995) almost one third of women with these conditions have been victims of childhood rape or incest.¹⁵⁵

In addition to the conditions mentioned, problems reported 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: venereal disease; pelvic inflammatory disease; respiratory problems and neurological problems (Sharkansky, 2005).¹⁵⁶

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.¹⁵⁷

2.4 OTHER CONSEQUENCES

SEXUAL PROBLEMS

A Queensland University study has linked childhood sexual abuse to sexual dysfunction later in life for both men and women (Dunne et al., 2005).¹⁵⁸ Adults abused as children often report sexual frigidity, dissatisfaction with sex, and difficulty sustaining intimate personal relationships, (Gold, 1986).¹⁵⁹

In a Los Angeles epidemiological study, Stein et al., (1994)¹⁶⁰ 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.¹⁶¹ As no control data was provided and the prevalence of sexual problems in the general population is high, no conclusion can be drawn.¹⁶²

DIFFICULTIES IN PREGNANCY, BIRTHING AND MOTHERING

Childbirth can be a particularly vulnerable time for women as they manage the physical and emotional demands of labour and delivery. 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.¹⁶³

Kitzinger (1997) emphasised the concerns of potential mothers with a history of childhood abuse about dangers that their children may face.¹⁶⁴ 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.¹⁶⁵

Some women also report distress during breastfeeding, with bodily contact and the sensations of breastfeeding evoking memories of sexual abuse (Prescott, 2002).¹⁶⁶ 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'.¹⁶⁷ 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

International studies have shown a high prevalence of the experience of abuse, particularly for women, both before, during and after episodes of homelessness. Homeless women often report multiple experiences of violent victimisation at the hands of multiple perpetrators, beginning in childhood and extending into adulthood.¹⁶⁸

An Australian study of homeless men and women Sydney (Buhrich, Hodder, & Teeson, 2000) found that half of all the women and 10% of the men had been raped in their lifetime (for men, the experience of rape usually occurred in an institutional setting). In another study, domestic violence was the primary cause of homelessness for 21% of women, while 36% had experienced: *a lifetime punctuated by violence and abuse*, including sexual assault and abuse (Grigg & Johnson, 2007).¹⁶⁹

On Australian Census Night (2001), 99,900 people were homeless of whom 14% were 'sleeping rough.' Almost 50% of the homeless population were less than 24 years of age, and 36% were aged 12–24 years. Overall, females represented 42% of the total. Of the total figure, 42.2% were in NSW.¹⁷⁰ 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.¹⁷¹

Supported Accommodation Assistance Program (SAAP) data showed that 18% of their clients were Aboriginal or Torres Strait Islanders. People aged 18 and 19 years had the highest rate of SAAP service usage at 145 clients for every 10,000 in the general population.¹⁷²

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.¹⁷³

Chamberlain and MacKenzie (2003) suggest that homelessness is: *best understood as a process, or series of biographical transitions*. 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*.¹⁷⁴

The Government's White Paper on Homelessness in 2008 aiming to reducing homelessness in Australia¹⁷⁵ highlights several factors, which identify the character of homelessness, several of which closely relate to child sexual and physical abuse, mental illness and substance abuse.¹⁷⁶

The close relationship between abuse and the continuation of young people remaining homeless is striking. Tully (2003) referred to abuse as the primary factor causing young people to seek safety by leaving home.¹⁷⁷ Having become homeless, young people are at further risk of abuse. The Living Rough Report (1999) identified that during a twelve month period 52% of homeless youth had been sexually assaulted.¹⁷⁸ The Salvation Army report *No Place that's Home*, states that 45% of homeless young people report sexual or physical abuse as a major factor in leaving home (Smith, 1995).¹⁷⁹

Similarly, 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 and 15 years.¹⁸⁰ Tully suggests that a culture of silence minimises the impact of CSA and reduces the likelihood that young people will link with appropriate services.¹⁸¹

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.¹⁸²

2.5 COST TO THE COMMUNITY

HEALTH UTILISATION

Women with sexual assault and abuse histories present with physical problems with greater frequency than those women who have not experienced sexual abuse. *Women adult survivors represent the greatest percentage of women requiring services from Women's and community health centres and mental health services* (NSW Health, 1998).¹⁸³ Unfortunately there is little more recent data, but 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.¹⁸⁴ Comparative studies in the USA have shown similar rates of mental health service utilisation.¹⁸⁵

A study by Walker et al. (1999) in the USA 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.¹⁸⁶

Survivors of CSA 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 (eg. theft) (Koss et al., 1991).¹⁸⁷

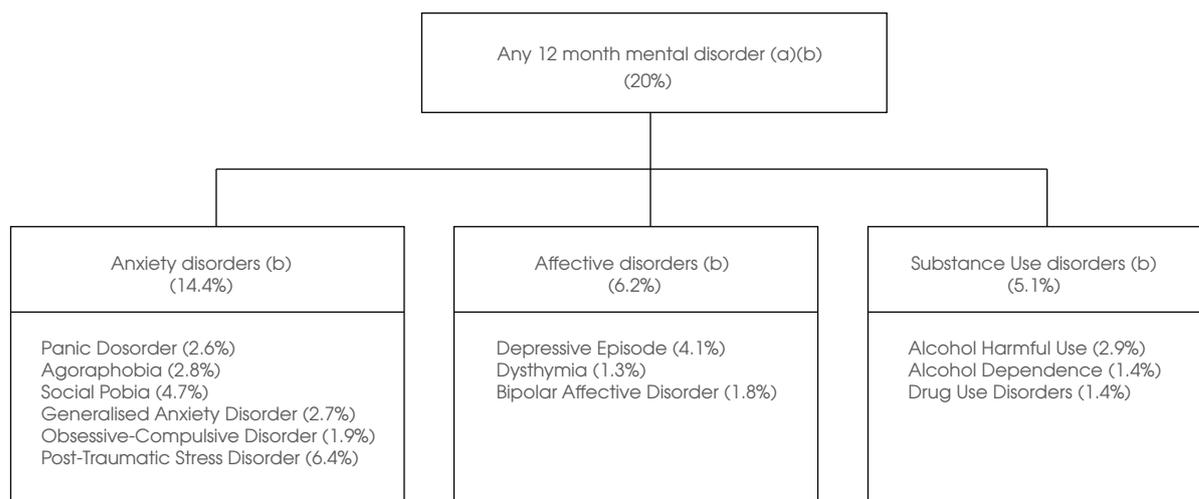
THE COST OF MENTAL HEALTH IN AUSTRALIA

The comprehensive assessment of the health status of Australians: *The burden of disease and injury in Australia 2003*, published in 2007 states that:

*Child sexual abuse was responsible for 0.9% of the total burden of disease and injury in Australia in 2003. Ninety-four per cent of this burden was due to anxiety and depression; suicide and self-inflicted injuries and alcohol abuse. Of the 14 risk factors examined, child sexual abuse was the second leading cause of burden in females under the age of 45. Just over four-fifths of the burden from child sexual abuse was experienced by females and 14% was due to mortality. The burden from child sexual abuse, both in terms of rate per head of population and in absolute terms, peaked at around 40 years-old then declined with age. The contribution from anxiety and depression dominated at this age after which contributions from suicide and self-inflicted injuries and alcohol abuse became increasingly important.*¹⁸⁸

Begg et al. (2007).
The burden of disease and injury in Australia 2003.

According to the ABS (2007) the prevalence of mental disorders is the proportion of people in a given population who meet the criteria for diagnosis of a mental disorder at a point in time. The diagram below shows the 12-month prevalence rates for each of the major disorder groups (Anxiety, Affective and Substance Use) and prevalence rates for each of the mental disorders within each group.



- (a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.
 (b) A person may have had more than one mental disorder. The components when added may therefore not add to the total shown.
 (c) Includes Severe Depressive Episode, Moderate Depressive Episode, and Mild Depressive Episode.
 (d) Includes Harmful Use and Dependence.

Australian Bureau of Statistics (2007).
National Survey of Mental Health and Wellbeing: Summary of Results.

Part 1: Understanding the Context

There were 3.2 million people who had a 12-month mental disorder. In total, 14.4% (2.3 million) of Australians aged 16–85 years had a 12-month Anxiety disorder, 6.2% (995,900) had a 12-month Affective disorder and 5.1% (819,800) had a 12-month Substance Use disorder.¹⁹⁰

Women experienced higher rates of 12-month mental disorders than men (22% compared with 18%). Women experienced higher rates than men of Anxiety (18% and 11% respectively) and Affective disorders (7.1% and 5.3% respectively). However, men had twice the rate of Substance Use disorders (7.0% compared with 3.3% for women).¹⁹¹

According to the AIHW (2009) the national recurrent expenditure on mental health services in 2006–07 was estimated to be \$4.7 billion. Of this total, 62% (\$2.9 billion) came from state and territory governments, 34% (\$1.6 billion) from the Australian Government and the remaining 4% (\$177 million) from private health insurance funds.¹⁹²

An estimated 12 million GP–patient encounters in 2007–08 involved management of a mental health issue, with the number of encounters growing by an annual average of 4.4% since 2003–04. The majority of these encounters were not claimed as Medicare mental health-specific items, and therefore are not included in the estimated national expenditure on mental health-related services. Community mental health and hospital outpatient services provided close to 6 million mental health-related service contacts to mental health consumers in 2006–07, an increase of more than 5% from 2005–06.¹⁹³

According to the report: *Mental Health services in Australia 2006–07*, there were 20 million mental health-related prescriptions subsidised through the Pharmaceutical Benefits Scheme in 2007–08 accounting for just over one in ten of all prescription claims. The number of prescriptions decreased by 0.4% per year on average, from 2003–04. Spending on these mental health-related prescriptions was over \$700 million with prescriptions for antipsychotics and antidepressants accounting for just over 90% of the total.¹⁹⁴

From 2002–03 to 2006–07, the number of beds in specialised psychiatric wards of public hospitals increased on average by just over 3% to around 4,200 beds, while over the same period, stand-alone public psychiatric hospitals beds decreased by 1.6% to just over 2,200 beds.¹⁹⁵

Collins and Lapsley (2008b) calculate the tangible social costs which are borne by the community as a result of alcohol and illicit drugs being consumed together amounted to \$1,057.8m. The total social costs of alcohol abuse (both tangible and intangible) in 2004/05 are estimated to be, at a minimum, \$15.3 billion, with a further \$1.1 billion attributable to the joint consumption of alcohol and illicit drugs.¹⁹⁶

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.



PART 2: SURVIVOR RESPONSES

CHAPTER 3

- 3.1 Attachment Theory
- 3.2 How children respond to abuse
- 3.3 Coping strategies, defence mechanisms and a sense of 'self'
- 3.4 Memory, traumatic amnesia and recovered memory
- 3.5 Resilience and recovery from child abuse



3.1 ATTACHMENT THEORY

Attachment theory is a theory of personality development arising from the work of John Bowlby (1969:1973:1980:1988). The theory clearly explains a diversity of negative outcomes experienced in adult survivors of childhood abuse, suggesting that early childhood relationships are internalised and inform an internal working model of the 'self' and the self in relationship with 'others'. Difficulties associated with abuse-related attachment are often mirrored in relationships throughout a survivor's life.

Bowlby (1988) describes four patterns of attachment which determine a child's reactions in the presence or absence of their primary caregiver (usually the mother): secure, ambivalent, avoidant and disorganised attachments.

1. Secure attachments: 'Securely attached' children develop inner working models that see others as positively available and themselves as lovable, valued and socially effective (Bowlby, 1988). Generally, adults who developed secure attachments as children have effective strategies for regulating affect (Alexander & Anderson, 1994).

2. Ambivalent attachments: 'Ambivalent' children experience parenting that is inconsistent, unreliable and emotionally neglectful. Persistent experiences of both emotional and physical neglect may lead children to suffer psychological distress resulting in feelings such as abandonment and rejection. The ambivalent child clings to the parent and exaggerates affect in order to take advantage of the intermittent responsiveness of their inconsistent parent. As an adult, the 'ambivalent child' may be described as clinging, jealous, obsessive, dependent, or self-sacrificing (Alexander & Anderson, 1994). 'Ambivalent' adults may be especially sensitive to the possibility of abandonment, rejection or isolation (Bowlby, 1988).

3. Avoidant attachments: 'Avoidant' children experience parenting that is hostile, rejecting and controlling. They experience little warmth or love and their emotional needs remain largely unmet (Bowlby, 1988). Parents of the avoidant child are not necessarily consistently rejecting; however, their coldness and lack of responsiveness are sure to emerge at the point when the child needed help. The parent of the avoidant child may respond positively to the child's autonomous behaviours but be mis-attuned to the child's request for nurturance (Alexander & Anderson, 1994). As a consequence, the learned response of the avoidant child is to hold back when feeling needy so as not to elicit even more rejection from the parent. This reluctance to express negative affect becomes internalised and may take form of compulsive self-reliance (Bowlby, 1969). As an adult the 'avoidant child' may be uncomfortable with intimacy, not confident about others' availability, highly self-reliant, seen as hostile to others, easily frustrated with partners, and overtly denying of problems while exhibiting covert symptoms of anxiety, distress, and dysfunction (Alexander & Anderson, 1994).

4. Disorganised attachments: The parent of the disorganised child tends to be frightening and/or frightened in his/her interactions with the child. Consequently, the disorganised child is in the untenable position of having to approach the very caretaker who is the source of the child's anxiety and fearfulness (Alexander & Anderson, 1994).

As adults 'disorganised children' they may see themselves as truly bad, responsible for their trauma and inherently flawed. They may experience significant distress, depression, and poor social adjustment (Alexander & Anderson, 1994).

Source references

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Attachment Questionnaire:

Those curious about their own attachment style can take the questionnaire developed by Shaver and colleagues at: <http://www.web-research-design.net/cgi-bin/crq/crq.pl>

3.2 HOW CHILDREN RESPOND TO ABUSE

COPING STRATEGIES

Children develop their sense of safety and security in an environment in which parents and caregivers provide love and understanding, care and support. Puttman (1997) posits that a child experiencing abuse develops strategies which become coping mechanisms enabling functioning, whilst becoming detached from the emotional and physical pain of events, especially when abuse continues over a protracted period.¹⁹⁷

Researchers have observed a number of different ways individuals respond to dangerous or abusive environments. The human body and human mind have a range of primitive, deeply ingrained physical and mental responses to threat of which there are two main types (ASCA, 2009):

- hyper-arousal continuum ('fight or flight'), i.e., vigilance, resistance (freeze), defiance, aggression
- dissociative continuum, i.e. avoidance, compliance (appease), dissociation, fainting.¹⁹⁸

A child may develop a: *style of relating whereby she psychologically attenuates or avoids certain attachment interactions with a given abusive caretaker* (Bowlby, 1988).¹⁹⁹ Whilst such defences are used to protect the child from overwhelming anguish and distorted environmental input, they also tend to reduce access to other positive attachments that may be available to them.²⁰⁰

Infants and children may be unable to use 'fight or flight' responses that are the natural responses of adults as they are rarely capable of being able to either fight or flee (Perry et al., 1995). Individual response will depend upon the age of the child and the nature of the threat. The younger the individual, the more likely he or she will use dissociative adaptations rather than hyper-arousal responses (Perry et al., 1995).²⁰¹

When in distress, a young child may for example cry to alert a caretaker that he/she is under threat. This is a successful adaptive response if a caregiver takes appropriate action. If a child's cries for help are ignored and no help arrives, or if the trauma is being inflicted by the actual caregiver, the child may shift from hyper-arousal to dissociation (Perry et al., 1995).²⁰²

Abused children appear to exist in a constant state of autonomic arousal described as '*frozen watchfulness*,' whilst avoiding display of inner agitation (Herman, 2001).²⁰³ 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).²⁰⁴

A protracted threat may cause a child to 'freeze'. Internally, the freeze response increases anxiety and decreases cognitive processes that enable one to 'figure out' how to respond (Perry et al., 1995). Being motionless is an effective camouflage reducing the likelihood of attracting a predator.²⁰⁵

Traumatised children often use this cognitive or physical freezing mechanism when anxious or out of control, for example when told that an abuser will be visiting. In such cases the child may act as if refusing to follow instructions. Non-compliance may lead to circumstances which inevitably make a child feel more anxious and out of control. The more anxious the child feels, the more readily the child will move from anxious to threatened, and then from threatened to terrorised. If sufficiently terrorised, 'freezing' may escalate into complete dissociation (Perry et al., 1995).²⁰⁶

Convinced of their powerlessness and the futility of resistance Herman (2001) writes: *The perpetuation of violence, threats, capricious enforcement of rules instill the terror and development of automatic obedience, isolation and secrecy, and fear of betrayal can destroy the relationships that would otherwise offer protection.*²⁰⁷

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 that other responsible adults are complicit and failing to protect her.

Victims frequently feel abandonment more acutely than the abuse itself, particularly if other adult carers were disarmed by intimidation and failed to intervene.²⁰⁸ Faced with profoundly chaotic relationships the abused child experiences overwhelming developmental challenges.

The child must identify 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. To maintain hope and meaning, a child will often preserve faith in her parents or caregivers, constructing explanations absolving them from blame and responsibility to accommodate primary attachment to the caregivers (Herman, 2001).²⁰⁹

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).²¹⁰

Whilst not all abused children develop an ability to dissociate, even those who 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 (Herman, 2001).²¹¹

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 affection 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.²¹²

3.3 COPING STRATEGIES, DEFENCE MECHANISMS AND A SENSE OF 'SELF'

COPING STRATEGIES AND DEFENCE MECHANISMS

Adult survivors will characteristically use strategies and defence mechanisms in order to keep them from feeling overwhelmed by threatening and dangerous feelings; and to manage their perceived sense of helplessness, powerlessness and lack of control. Herman (1997, p. 96) suggests that the trauma of child abuse requires children to develop extraordinary coping strategies which in childhood enabled the child to 'survive' and manage their traumatic experiences.

"I have always worked really hard at everything. When I was studying social work I was always the last to leave and could never finish my assignments because there were always more things to say. Then at work I used to be there till all hours of the night because the more I did, the more I could help my clients but of course I was ignoring my own needs. Sometimes I just can't stop and the more I do, the better I feel."

However such mechanisms may impair the development of more appropriate or adaptive social, cognitive, and emotional coping mechanisms for adult life, and have negative impacts for the development of a sense of self (ASCA, 2009).²¹³ The adult may become the: fighter, the accommodator, the escape artist, the victim, the denier, the over-achiever, and the 'pleaser' (van Loon & Kralik, 2005c).²¹⁴

"I can't bear conflict, I do everything I can to make everyone happy, I never say what I want, everyone else comes first....meanwhile I am seething inside, why doesn't anyone ever think about me? Oh Cheryl, you are always so NICE, you don't mind if I walk right over you to get what I want....well yes I do, but I'm too frightened to say so."

Welch Ross presented a model for the emergence of autobiographical memory defined as: *a collection of memories for personally experienced events that was relevant to one's sense of self and this constituted a person's life history* (1995, p. 338).²¹⁵ Violation, particularly sexual abuse shatters the sense of self, which may leave a survivor with an intense sense of insecurity, a lack of self-esteem, difficulty relating to other people, poor frustration tolerance, overwhelming emotions, depression, sensitivity to criticism and rejection, distrust, and suspicion.

A number of studies have assessed the coping strategies used by adult survivors. For example Morrow and Smith (1995) suggest that strategies used by survivors of childhood abuse can be conceptualised as:

- a. keeping the survivor from being overwhelmed by threatening and dangerous feelings
- b. managing helplessness, powerless and lack of control^{216 217}
- a. Strategies to keep from being overwhelmed by threatening and dangerous feelings:
 - o Reducing the intensity of troubling feelings (dissociative techniques)
 - o Avoiding or escaping the feelings (drug and alcohol; dissociative techniques)
 - o Exchanging overwhelming feelings for other, less threatening ones (self-harming behaviours)
 - o Discharging or releasing feelings (acting out; anger; shouting; cutting; passive aggression)
 - o Not knowing or remembering experiences that generated threatening feelings (repressed memory or traumatic amnesia)

- Dividing overwhelming feelings into manageable parts—separating emotions from cognitions, sensations, behaviours (dissociation/splitting i.e. good/bad).²¹⁸
- b. Strategies used to manage helplessness, powerlessness and lack of control:
 - Rejecting intimacy and trust (avoid relationships, sex and friendship)
 - Creating resistance/defence strategies
 - Reframing abuse to create an illusion of control or power (denial; rationalising; minimising; projection)
 - Attempting to master the trauma (being compliant; become an advocate of other abused people)
 - Attempting to control other areas of life (self-harming and/or obsessive behaviours; eating disorders; workaholic; isolate)
 - Seeking confirmation or evidence from others (validation; please and appease)
 - Rejecting power/authority (rebel; refuse help).²¹⁹

Morrow, S. L., & Smith, M. L. (1995).
Constructions of survival and coping by women who have survived childhood sexual abuse.
Journal of counselling psychology, 42, 24–33.

DEFENCE MECHANISMS

Total action defences – Releases feelings and impulses through action, often toward others:

- *Acting out* – Expression of feelings or impulses in uncontrollable behaviour with disregard for consequences
- *Hypochondriasis* – Covert hostility is expressed as the subject asks for help but rejects the suggestions/help offered
- *Passive aggression* – Indirectly expressing aggression toward others; overt compliance making covert resistance.

Major image-distorting defences – Distorts self and object images to conform with a particular meaning or emotional state:

- *Splitting self* – Failing to integrate the positive and negative qualities of self or others into cohesive images
- *Projective identification* – Projecting personally acknowledged affects or impulses onto someone else, as if the other person originated the affect or impulse
- *Autistic fantasy* – Daydreaming as a substitute for human relationships or more direct and effective action.

Total disavowal and fantasy defences – Disavows experiences, affects, or impulses:

- *Denial* – Refusing to acknowledge aspects of external reality
- *Rationalisation* – Devising reassuring or self-serving but incorrect explanations for behaviour
- *Projection* – Disavows unacknowledged feelings, impulses, or thoughts by attributing them to others.

Minor image-distorting defences – Regulates self-esteem and mood by focusing on over or undervalued aspects of experience, self, and others:

- *Devaluation* – Attributing exaggerated negative qualities to oneself or others as a dismissal.
- *Omnipotence* – Acting superior to others, as if one possessed special powers or abilities.

- *Idealisation* – Attributing exaggerated positive qualities to self or others

Other neurotic defences – Distorts content of experience while appropriate affect remains intact:

- *Displacement* – Redirecting a feeling about an object on to another, usually less threatening, object
- *Repression* – Being unable to remember, or be cognitively aware of, disturbing wishes, thoughts, or experiences
- *Reaction formation* – Substituting behaviour, thoughts, or feelings that are the opposite of the unacceptable feeling
- *Dissociation* – Both the idea and the associated affect or impulse remain out of awareness but are expressed by an alteration of consciousness.

Obsessional defences – Neutralises affects without distorting external reality:

- *Isolation* – Being unable to experience the affective components of a situation
- *Intellectualization* – Excessive use of abstract thinking or generalizing to avoid experiencing disturbing feelings
- *Undoing* – Words or behaviours designed to symbolically make amends to previous thoughts, feelings, or actions.

In contrast to the defence mechanisms listed above, mature defences provide a positive frame with which a person can deal with difficulties. This can be accessed in relation to constructive coping mechanisms.

Mature defences – Constructive, non-reality distorting problem and emotion-focused coping:

- *Self-observation* – Reflecting on one's thoughts, feelings, motivation and behaviour
- *Self-assertion* – Expressing one's feelings and thoughts directly in order to achieve goals
- *Affective rehearsal* – Anticipating emotional reaction to future problems
- *Humour* – Emphasising the amusing or ironic aspects of the conflict or stressor
- *Sublimation* – Channelling feelings or impulses into socially acceptable behaviour
- *Suppression* – Voluntarily avoiding thinking about disturbing problems or experiences temporarily
- *Altruism* – Dedication to fulfilling the needs of others
- *Affiliation* – Turning to others for help and support.

Source: Mounier & Andujo (2003), adapted from Perry (1990).
*Perry's defence mechanism rating scale.*²²⁰

SENSE OF SELF

Normal thought patterns of self-blame and loss of self-esteem in early childhood, are congruent with thought processes of traumatised people of all ages. Persistent childhood abuse reinforces the propensity towards self-blame and lack of worth, where neither time nor corrective experience can alter this perception.

"I was always told I was a useless nuisance and more trouble than I was worth. The idea stuck. As I grew up I always seemed to end up with partners who abused and denigrated me, but I couldn't leave. Until recently that was all I thought I deserved, now I know better".

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.

"At work when someone makes a comment I often think it's aimed at me and I get really angry. I sort of know that I shouldn't be that angry because the comment wasn't all that bad but I can't help it. I used to explode but at least I don't do that now but I go home and brood and it often takes me a few days before I can talk to anyone again. I never talk about what made me angry though because no one would understand."

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).²²¹

"I've never had a boyfriend, I avoid anything social. I eat alone and lots. My fat keeps me safe and secure, no one invades my space now, no-one will do what he did to me. I'm in control now. It is lonely though".

The negative belief system 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).²²²

"I'm 36 and my friends think I'm strange because I've never had a real boyfriend. I want to and all but whenever I like someone I get scared and do something to turn them off me. I am so scared of being touched and yet I really want to be close to someone and have someone special. I don't think it will ever happen though because I don't deserve to be loved."

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.²²³

"I don't think anyone likes me much but that's okay because I don't really like people that much either. People just pretend to be nice but they're not really; they go behind your back and say mean things about you and they're just there to look after themselves and make themselves feel good. That's okay because I like being by myself. That's how I've always been and it's better that way. At least then I don't get hurt."

3.4 MEMORY, TRAUMATIC AMNESIA AND RECOVERED MEMORY

NORMAL MEMORY

From the beginning of an infant's life the mind/brain is organising experiences and stimuli and attempting to make sense of them. Memory refers to a number of processes in which mind/brain is able to perceive a stimulus, encode elements of it and then store these for later retrieval. It is reconstructive, not reproductive, and influenced by mental models or schemata which link together perceptual biases, associated with memories, emotions and prior learning.

Siegel, D. (1995). *Cognition and Perception In Comprehensive textbook of psychiatry* (6th edn) (eds Kaplan, H. J. & Sadock, B. J.), 277–291. New York: Williams & Wilkins. Siegel, 1995)

IMPLICIT AND EXPLICIT MEMORY

Some forms of remembering involve conscious awareness (explicit or declarative memory), whilst others are not easily accessible to consciousness and can influence behaviour (implicit or procedural memory). These forms of memory depend on different brain structures.

Implicit memory is likely to reside in brain structures that mediated its initial encoding (e.g. basal, and amygdala and possibly motor, somatosensory cortices) and includes information acquired during skill learning, habit formation, simple classic conditioning, and other knowledge that is expressed through performance rather than recollection.

Squire, L. R. (1992a). *Declarative and non-declarative memory: multiple brain systems supporting learning and memory*. *Journal of Cognitive Neuroscience*, 4, 232–243.
In: Siegel, D. (1995). *Cognition and Perception*. *Comprehensive textbook of psychiatry* (6th edn) (eds Kaplan, H. J. & Sadock, B. J.), 277–291. New York: Williams & Wilkins.

Explicit memory is what people generally think of as ‘memory’ in which an event can be recalled as if it were from the past and communicated to others as such (Squire, 1992a). This requires conscious attention for processing (thought to be mediated via the medial temporal lobe system which includes the hippocampal formation and related structures. Hippocampal processing is dependent on an easily disrupted neurophysiological process called long-term potentiation (Squire, 1992a, b).

By the separate process of cortical consolidation which takes days to weeks to months, memories are made ‘permanent’ in the cortex and independent of the hippocampus for retrieval.

Studies of the development of memory (Fivush & Hudson, 1990; Nelson, 1993a) suggest that:

- a) children have excellent encoding and retrieval capacities for implicit memory from early on
- b) explicit memory encoding may be good, but retrieval strategies for young children are immature and this may lead to the observed limitations and inconsistencies in cued and spontaneous recall for personally experienced events
- c) the nature of post–event dialogue regarding an experience can influence the manner and probability of recall of aspects of the experience (Ceci & Bruck, 1993)
- d) emotional states bias the interpretation of stimuli, encoding and the retrieval of memories in the process known as state-dependent learning (Bower, 1987; Eich & Metcalfe, 1989; MacLeod, 1990).

Source: Siegel, D. (1997) *Psychological trauma: A developmental approach*. Black, E., Newman, D., Harris-Hendrick, M., & Mezey, J. G. (1997) Royal College of psychiatrists: Gaskell, UK, p.44, 45.

Source references

Bower, G. H. (1987) *Commentary on mood and memory*. *Behaviour Research and Therapy*, 25, 443–456.

Ceci, S. & Bruck, M. (1993). *Suggestibility of the child witness: a historical review and synthesis*. *Psychological Bulletin*, 113, 403–439

Eich, E. & Metcalfe, J. (1989). *Mood dependent memory for internal vs. external events*. *Journal of Experimental Psychology: Learning, Memory and Cognition*, 15, 443–455.

Fivush, R. & Hudson, J, A. (1990). (eds) *Knowing and remembering in Young Children*. Cambridge: Cambridge University Press.

MacLeod, C. (1990). *Mood disorders and cognition*. In: Cognitive Psychology – An International Review (ed. Eysenck, M.W.), p.p. 9–56, Chichester: John Wiley.

Nelson, K. (1993a). *The psychological and social origins of autobiographical memory*. Psychological Science, 2, 1–8.

Siegel, D. (1995). *Cognition and Perception In Comprehensive textbook of psychiatry* (6th edn) (eds Kaplan, H. J. & Sadock, B. J.), p.p. 277–291. New York: Williams & Wilkins.

Siegel, D. (1997). *Psychological trauma: A developmental approach*. Ed Black, D, Newman, M, Harris–Hendrick, J, & Mezey, G (1997) Royal College of psychiatrists: Gaskell, UK, p.44, 45.

NARRATIVE ATTACHMENT AND MEMORY

The development of explicit, autobiographical memory in children has been found to be particularly influenced by ‘memory talk’, in which adults (usually parents) talk to children about the contents of their memory (Nelson, et al., 2004). This enhanced recall may be due to the reinforcing impact of such talk, the learning about ‘how to remember’ as well as the co-construction of a narrative about events.

Studies suggest that there may be confirmation of this from attachment theory. For the parents of the avoidantly attached children there is a fascinating set of converging findings. One of the characteristics of parents of the avoidantly attached children is that they insist on an inability to recall their childhood experiences. The first year of life of their infants was marked by mother–child relationship which was emotionally distant and rejecting (Ainsworth et al, 1978). On follow ups at ten years of age, a sample of avoidantly attached children had a unique paucity in the content of their spontaneous autobiographical narratives (Main, 1991). Ainsworth et al., (1978) suggests that: *Perhaps the parents of these avoidantly attached children do not engage them in talking about events which will become memories (co-construction of narrative), and thus the accessibility of those memories for those experiences is greatly diminished.*

Source references:

Ainsworth, M. D., Blehar, M.C., Waters, E. I. (1978). *Patterns of Attachment*. Hillsdale, NJ: Lawrence Erlbaum.

Main, M. (1991). *Metacognitive knowledge, metacognitive monitoring, and singular (coherent) vs. multiple (incoherent) models of attachment: findings and direction for future research*. In: *Attachment Across the Life Cycle*. (eds. Marris, P., Stevenson-Hinde, J., & Parkes, C.). New York: Routledge.

Nelson, K. & Fivush, R. (2004). *The Emergence of Autobiographical Memory: a social cultural developmental theory*. Psychological Review, 111: 486–511.

RECOVERED MEMORY

Dalenberg (2006) states that: *earlier literature typically refers to repressed memory, whereas more recent literature refers to recovered memory.*²²⁴ The phenomenon of repressed memory represents the recovery of memories previously inaccessible to the individual. *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* (Thomson, 1995, p. 97).²²⁵

“I was leading a perfectly normal family life but when my daughter got to four years old I completely fell apart. She so reminded me of myself. I couldn’t

bear to let my husband bath her. I would go into total panic and start to hyperventilate. I couldn't understand what was happening."

Repression is a core concept of psychoanalytic 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.²²⁶ This response relegates the event to the subconscious.

It has long been accepted that during periods of stress and fear that a number of chemicals are released that have an effect on learning and memory.²²⁷ Reviews of the neurology of the dissociative amnesia (another term for repressed memory) and dissociative defences conclude that Neuro-chemicals released during stress can either enhance or impair memory.²²⁸ 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, a survivor may engage in a number of strategies such as substance use and self-harming behaviours in order to 'self soothe,' (the capacity to comfort oneself). These behaviours may present as survival strategies or coping mechanisms.²²⁹

"When I cut myself I felt such relief, there was no pain, my anxiety just floated away. I was somewhere else. I don't do that anymore but I have tattoos everywhere on my body, they are my badges of honour, I survived and each tattoo tells a story of that survival."

"I cut myself to prove I exist."

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 at a service and is often the motivating factor for seeking assistance.

"I didn't know what was happening to me at first. I thought I was going crazy. I was having all these strange feelings and sensations and doing stuff that I didn't understand. It was very scary. I was reliving things I hadn't remembered had happened to me and they were so real. They were things from the past, horrible things and for a long time they filled my days. I still remember the first time I remembered I'd been raped. I couldn't actually remember it but I knew it had happened. It was so strange but then over the next few weeks I remembered some details around it but then I didn't want to believe it."

Cozolino (2002) describes reactions to trauma as predictable and related to well understood biological processes. In the absence of a supportive environment (creating the neurobiological conditions for the establishment of neural coherence) integrating cognition, affect, sensation and behaviours, an abused child may remain dissociated from the trauma forever.²³⁰

"When I was young I wasn't aware of how much I spaced out. Then I went through a few years of reliving my past and often I felt like I was living in two time zones simultaneously. I would have an awareness of where I was in the present but feel very dopey and zonked out. I'd be back at a different age; sometimes I was so little that I'd be speaking in a little girl's voice and all these things would be being done to me and I'd be really scared and not know what was happening, except that I was terrified and really sore down below. It felt so weird, knowing I was an adult but yet being the child, and not just one child but a child of different ages and I couldn't connect any of those things which had happened to those children. They were all separate for a long

time. I often felt as though I was watching a video except I was starring in it. I can understand it now because if I'd let all those bad memories in when I was little I don't think I would have survived."

Traumatic amnesia and delayed memory retrieval of traumatic events has been documented since the days of Jean Martin Charcot and Sigmund Freud's studies of hysteria, and is now scientifically accepted in the context of war, accident or disasters.²³¹ While controversial during the 1980s to the early 90s the concept is now widely accepted in reference to child sexual abuse.

Freyd (1996) reported high instances of corroboration for previously amnesic clients with recovered memories of sexual abuse.²³² The frequency of recovered memory is well documented and the invalidation of uncertainty is no reason to conclude that memory is false or unreliable because recovering memory through the therapeutic process cannot be replicated in a laboratory.²³³ This is the consensus of opinion of practitioners working across theoretical boundaries in the mental health field.²³⁴

"I had no memory for 10 years of my childhood. When people asked me about what I'd done at school or anything like that I couldn't answer them and I'd get very angry. I had always just said that I had a bad memory and not wanted to accept how abnormal it was. When the memories started to come back I wanted to reject them because they were so horrible. I didn't want them but I needed to accept them and integrate them as they are part of what happened to me. I never wanted the past I had but now I know some of it and can function better because so much makes sense now."

Extensive research on traumatic amnesia points to the significance of the victim's age at the time of the abuse as well as 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).²³⁵

REBUILDING NEURAL PATHWAYS

The therapy model utilised with traumatised individuals should ideally aim to increase neural integration, which is increased when a person is supported to remain within their window of tolerance and, previously dissociated cognitions, affect and body sensations are reconnected. With neural integration comes better regulation of the ANS and associated symptom reduction. Traumatic experiences can then be assigned to the past, where they belong, and the once traumatised individual is released from the cyclic nature of trauma.

The autonomic nervous system (ANS or visceral nervous system) is the part of the peripheral nervous system that acts as a control system functioning largely below the level of consciousness, and controls visceral functions. The ANS affects heart rate, digestion, respiration rate, salivation and perspiration, diameter of the pupils, urination and sexual arousal. Whereas most of its actions are involuntary, some, such as breathing, work in tandem with the conscious mind.

3.5 RESILIENCE AND RECOVERY FROM CHILD ABUSE

RESILIENCE

Resilience refers to the capacity of human beings to survive and thrive in the face of adversity. It is a term that can be applied to people at any ages. For a child who has been abused, their interpretation of the abuse, whether or not they disclose the experience, and how quickly they report it can affect short and long-term consequences. Children able to confide in a trusted adult and who are believed, generally experience less trauma than children who do not disclose the abuse. Moreover, children who disclose soon after the abuse may be less traumatised than those who live with the secret for years.

Some researchers have begun to look at the question of whether someone can recover from abuse, and, if so, what factors help in that recovery. One of the strongest predictors of the child's recovery from the abuse experience is a high level of maternal and family functioning. (This, of course, assumes that the abuser was not a member of the immediate family or, if so, is not still living within the family). Children and adults who were sexually abused as children have indicated that family support particularly from their mother, extra-familial support, high self-esteem and resilience, and spirituality were helpful in their recovery from the abuse.

Evidence has demonstrated that self-blame is predictive of more PTSD symptoms and poorer recovery (Koss, Figueredo, & Prince, 2002; Frazier, 2003) and conversely perceived control over recovery is associated with less distress (Frazier, 2003) in child sexual abuse survivors.²³⁶

Child sexual abuse characteristics such as maladaptive coping responses; the degree of self-blame at the time of the abuse and currently, and PTSD were examined as predictors of re-victimisation. Results indicated that individuals who reported both CSA and adult sexual assault had more PTSD symptoms, were more likely to use drugs or alcohol to cope, act out sexually, withdraw from people, and seek therapy services.²³⁷

"For a long time I blamed myself for what had happened to me, for not being able to say no and stop the abuse. I really struggled to accept what I was remembering and while I continued to reject my history I used to get a lot of panic attacks, and was very depressed. The flashbacks were coming thick and fast and I'd spend lots of time in bed in between, trying to escape the world, curling up and not wanting to see or speak with anybody. I would withdraw and stay really isolated because that was familiar to me. Yet it was not healthy because I needed to connect. The isolation put me at much greater risk and I had lots of suicidal thoughts then. I really did think I'd be better off dead."

It is important for survivors to be able to relinquish any guilt and blame they may feel about the abuse. Survivors report that access to information and attending workshops and conferences on child abuse, reading about child abuse, and undergoing psychotherapy have helped them on their road to healing and to return to a more rewarding life.

*Child sexual abuse and its effects never completely determine a person's identity. Women and children's resilience, strength and determination to resist the training about who they should be, and how they should live their lives, should never be underestimated.*²³⁸

Source: Dymyna House. (1998). *Info Kit: A Booklet on Childhood Abuse*. Dymyna House Child Sexual Assault Counselling and Resource Centre, p.34.

In cases of familial abuse, a supportive, non-offending parent seems to be strongly correlated with resilience.²³⁹ A calm, practical, positive and supportive, approach by the person to whom the abuse is disclosed may greatly reduce the impact of the abuse. However, this may be extremely difficult for the parent torn between loyalty to and love of a partner, family member or friend and their role as a responsible parent who loves and wants to believe their child. It may also be difficult for the person in authority torn between loyalty to a colleague and their institution and responsibility for the child. Whatever the circumstances, the child must always be the first priority.²⁴⁰

The importance of the initial response suggests that efforts to prepare and assist parents and caregivers to acknowledge and support any child who discloses abuse are likely to have significant benefits.²⁴¹ Similarly, the response to disclosure by adult victims is critical since these people have lived with the secret of abuse for many years. Failure to respond appropriately, either personally or institutionally can have a devastating effect on these adults, their families and others close to them.²⁴²

People who are able to utilise 'Approach' strategies are more likely to experience greater 'Resilience' in terms of their ability to enjoy better mental health and constructive relationships. These strategies include, seeking information and support and planning to reduce stressors rather than minimising or using avoidance strategies to resolve stressful feelings. Survivors of CSA frequently are unable to bring such strategies to bear until they have engaged in therapeutic processes.

CHAPTER 4

- 4.1 Vulnerability and re-victimisation
- 4.2 Culturally appropriate services
- 4.3 Access and equity



4.1 VULNERABILITY AND RE-VICTIMISATION

For those advocating for and working with adult survivors of childhood abuse the issue of re-victimisation is one that needs to be acknowledged and articulated. Survivor stories often include expression of both self-blame and the blame imposed on them as victims by family; society as well as when accessing services.

There is a substantial body of literature on the survivor characteristics which increase vulnerability for victimisation in adulthood. Many researchers are currently shifting their attention to perpetrators and the effects of societal and cultural responses to violence against women (Messman & Long, 2003).²⁴³

*Re-victimisation is also a common phenomenon among people abused as children. Research has shown that child sexual abuse victims are more likely to be the victims of rape or to be involved in physically abusive relationships as adults.*²⁴⁴

American Psychological Association. (2006). *Understanding Child Sexual Abuse*. Education, Prevention and Recovery.

Extreme experiences of victimisation are associated with symptoms of Borderline Personality Disorder (BPD). As defined by APA (1994), personality disorders are characterised by symptoms associated with maladaptive and inflexible personality traits. BPD is characterised by enduring patterns of instability in relationships, goals, values, and mood, non-fatal suicidal behaviour and suicidal threats and other impulsive behaviours that may be harmful (such as substance abuse or unsafe sex). Research has shown that among the most severely impacted survivors of childhood sexual trauma, such as women in high security psychiatric hospitals, BPD is a common diagnosis (Warner & Wilkins, 2004).²⁴⁵

Back in 1995, Candib 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 (2005, p.17).²⁴⁶ 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.

As mentioned earlier in this Workbook (section 2.2) the literature on BPD among sexual trauma survivors has caused some researchers and clinicians to advocate for the use of a Complex PTSD diagnosis. A diagnosis of Complex PTSD includes the behavioural characteristics of BPD.

This disorder is associated with experiencing an interpersonal stressor, including symptoms related to mood swings, changes in states of consciousness, physical symptoms without a medical diagnosis, and altered sense of self and others (Pelcovitz et al., 1997). In a recent study, women with a history of childhood sexual trauma met the diagnostic criteria for both BPD and Complex PTSD (McLean & Gallop, 2003). As a result, the researchers suggested that survivors might be better understood with the single diagnosis of Complex PTSD.²⁴⁷

Herman (1992) proposed the syndrome of Complex PTSD since abused 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 (section 2.2).²⁴⁸

The diagnosis of a BPD has been historically stigmatising and controversial because it implies that the individual's personality is flawed and may not be altered or changed. Stigma surrounding this disorder has also developed from observations that individuals with these symptoms are particularly difficult to work with, and 'treat' and often

terminate treatment prematurely. Knowledge about this diagnosis, however, is vital to early detection and utilisation of specialised therapeutic approaches.²⁴⁹

One of the most promising treatments is Dialectical Behaviour Therapy (Linehan, 1993, section 6.9 of this workbook) which has been shown to be effective in reducing self-harming and impulsive behaviours; and substance misuse and alcohol use.

"People are such scumbags. They pretend to be your best friend and then they do something really horrible. Like that counsellor, Jen. She seemed really nice at first but then the other day when I needed her and kept calling and calling she didn't answer at all. And I was feeling really bad. I had to cut myself and it was all her fault. She's lucky I didn't go under that car because if I had it would have been on her head. Some counsellor, doesn't even answer when I call. Bitch!"

Childhood sexual trauma is also associated with other personality disorders, including those that are distinguished by enduring patterns of distrust and suspiciousness; grandiosity and need for admiration (i.e., Narcissistic Personality Disorder), social inhibition and feelings of inadequacy (i.e., Avoidant Personality Disorder), or submissive and clinging behaviour (i.e., Dependent Personality Disorder, APA, 1994). A recent study, however, found that individuals with BPD reported higher rates of sexual abuse compared to individuals diagnosed with other personality disorders (Yen et al., 2002).²⁵⁰

WOMEN IN THE CRIMINAL JUSTICE SYSTEM

Over the last two decades, both in Australia and internationally, numbers of women in the criminal justice system have increased by 260 percent. Increasingly women are going to jail for longer periods for minor crimes, most frequently related to drug and alcohol crimes or theft. The statistics for Indigenous women is even more alarming.

The profile of women in gaol speaks to the degree to which these women are marginalised in society. According to the 2008 NSW Inmate Census by Corrective Services NSW, women represent approximately 7.3% (n=720) of inmates in NSW (n=9859) of which 29% are Aboriginal. Previous research has identified that 30% of women in metropolitan prisons come from the three most disadvantaged Sydney suburbs.²⁵¹

The 2009 NSW Inmate Health Survey sampled women in prison (N=199) and found:

- 45% experienced domestic violence or abuse as an adult
- 80% are current smokers
- 38% consumed alcohol in a hazardous or harmful way in the year prior to incarceration, with 16% showing signs of dependent drinking
- 78% had used an illicit drug and 52% had injected drugs
- 20% have been admitted to a psychiatric unit or hospital
- 27% have attempted suicide
- 49% are mothers of children aged 16 or under
- 45% left school prior to completing year 10 at an average age of 14 years 32% were placed in care as children
- 67% were unemployed in the six months prior to incarceration; of these 25% had been unemployed for 10 or more years
- 66% have been in a violent relationship.

Source: Indig, D et al. (2010). *2009 NSW Inmate Health Survey: Key Findings Report*. Justice Health.

When we look at the life stories of women within the prison system, the distinctions between offender and victim become very blurred. Their crimes are primarily those of poverty and drug addiction.²⁵²

In Australia and internationally research evidence has shown that sexual and physical abuse features prominently in the lives of women offenders. In a paper by Johnson (2004) she refers to a number of studies which found that:

*...in Victoria 64 per cent of women in prison had a history of physical or sexual abuse, and the prevalence of physical abuse was twice as high for women with drug or alcohol abuse problems (74% compared to 36% of others) (Denton 1994); 42 per cent of women in Queensland prisons in 2002 were victims of sexual abuse before the age of 16 (Hockings et al. 2002); and in 2001, 77 per cent of women in West Australian prisons had a history of abuse, 74 per cent as an adult and 57 per cent in childhood.*²⁵³

WA Department of Justice. (2002). In: Johnson, H. (2004). *Drugs and Crime: A Study of Incarcerated Female Offenders*. Research and Public Policy Series No. 63. Australian Institute of Criminology

In Australia and internationally, research has provided strong evidence of a link between drug and alcohol abuse and physical and sexual abuse in childhood among incarcerated women. Physical and sexual abuse can have a range of negative short and long-term consequences, including running away, poor school success, low self-esteem and prostitution (WA Department of Justice, 2002; Jarvis, Copeland & Walton, 1995; Browne, Miller & Manguin, 1999; Shaw et al., 1991; Comack, 1996; Marcus-Mendoza, Sargent & Chong Ho, 1994; Fletcher, Rolison & Moon, 1994; Harlow, 1999).²⁵⁴

These studies suggest that the connection between drug and alcohol abuse and criminal offending may be mediated by factors associated with early experiences of abuse, such as psychological distress, trauma, other negative family experiences, and street life. A growing drug dependency may then lead to theft, drug-selling or prostitution to cover the cost of a drug habit, and often to support drug-addicted partners.

"The drug habit has turned me into a thief. I've been stealing for so long that the stealing has become a habit."

*"I started to drink and take drugs because of my anger and sadness about my childhood. I became a drunk, it was mainly because of my abuse as a child, but also because of my family who all drank, had a criminal history, like everyone in the community I grew up in. Because of my offending it has affected everyone around me, my children.....I've lost my freedom, my family, my friends, my health, it has ruined my life. It has taken control of my life."*²⁵⁵

Adapted from: Australian Institute of Criminology, DUCO female survey (2003). Kerber, L., Maxwell, J. & Wallisch, L. (2001).

Substance use among offenders entering the Texas Department of Criminal Justice Substance Abuse Felony Punishment Facilities 1998-2000. Austin: Texas Commission on Alcohol and Drug Abuse.

Offenders in the Texas DUCO study were also asked if they ever experienced emotional, physical or sexual abuse in adulthood. Overall, 78% of women reported experiencing one or more of these types of abuse. Emotional abuse and physical abuse were most prevalent, each reported by about two-thirds of offenders. The primary perpetrators of emotional or physical abuse were spouses or partners.²⁵⁶

A NSW study in 2001 found that 70% of women in prison said that they had been abused as children, while 44 percent said that they had been abused as adults. This abuse often led to substance abuse, which in turn led to women committing offences and ending up in the prison system.²⁵⁷ In 2009, 87% reported experiencing at least one type of abuse as a child or an adult and half of all abuse victims reported four or more types of abuse in their lifetimes (Justice Health Inmate Survey (2009)).²⁵⁸

Drug and alcohol abuse and physical and sexual abuse in families of origin, and poor mental health in childhood, are important risk markers for drug dependency, persistent offending and involvement in sex work later in life. The majority of incarcerated women in the DUCO study mentioned earlier have children and these children are at risk of repeating the cycle of drug dependency and criminal offending due to their exposure to drug use by their mothers.

In order to draw a comparison between women in the justice system and women surveyed in the community it is useful to look at the figures from the Australian component of the International Violence Against Women Survey (IVAWS) in which a total of 6,677 women aged between 18 and 69 years participated in the telephone survey between December 2002 and June 2003. This provided information about their experiences of both physical and sexual violence. As the IVAWS was a telephone survey, participation was limited to women living in private residences who had telephones. This resulted in the experiences of particular groups of women being significantly under-represented or excluded entirely; in particular, women who are homeless, women living in rural or remote communities, Indigenous women, women with disabilities, and women who are not English-speaking. However, the survey did capture the experiences of 92 Indigenous women and 1122 women from non-English speaking backgrounds.²⁵⁹

Surveying experiences across women's lifetimes the IVAWS survey found that:

- Over half of the women surveyed (57%) had experienced at least one incident of physical or sexual violence over their lifetime.
- 18% of women reported being sexually abused before the age of 16: almost 2% of women identified parents (fathers in all but two cases) as the perpetrators, while a further 16% identified someone other than a parent. The results suggested that the risk of sexual violence in adulthood doubles for women who experience child abuse.²⁶⁰

4.2 CULTURALLY APPROPRIATE SERVICES

At a systems level, services struggle with embedding and 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).²⁶¹

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 generally but do engage when mental health problems become chronic, but only for shorter periods of time (McKendrick & Thorpe, 1994, Vicary, 2002).²⁶²

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).²⁶³

The report, *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*.²⁶⁴ Components of cultural competence have been defined in reference to different competencies: cultural awareness and beliefs, cultural knowledge and flexibility (Cross et al., 1989).²⁶⁵ 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).²⁶⁶

However, attempts have been made to define and operationalise the basis of cultural inappropriateness, and provide methods by which clinicians might adapt their practice. The NSW Aboriginal Mental Health and Well Being Policy 2006–2010 is a framework to guide NSW Health and NSW Area Mental Health Services (AMHSs) in the provision of culturally sensitive and appropriate mental health and social and emotional well being services to the Aboriginal community of NSW.²⁶⁷

Similarly, it is important to acknowledge the work of the NSW Transcultural Mental Health Centre (TMHC) a state wide service established in 1993. The TMHC's mission is to work in partnership with mental health services, consumers, carers and the community to improve the mental health of people from culturally and linguistically diverse communities living in NSW. TMHC's programs emphasise the importance of recognising and responding to cultural, linguistic and religious diversity in improving the mental health and well being of people from CALD communities.²⁶⁸

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, it is important to support 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.²⁶⁹ However, Garrett (1992) acknowledges the difficulties in supporting large numbers of diverse cultural groups with specialist knowledge.²⁷⁰

4.3 ACCESS AND EQUITY

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.²⁷¹ The principle involves promotion through practice, and participation in all processes that affect consumers' lives. This should not be forgotten or ignored in relation to survivors of CSA.

In line with Recovery Principles (section 5.3) paramount to the process of recovery is the opportunity for survivors to contribute meaningfully to service delivery-planning, education and training, employment, evaluation and involvement in improving quality outcomes and promoting access and equity (MHCC, 2008).²⁷²

ACCESS AND EQUITY

Access implies recognising cultural diversity, and identifying and addressing barriers and structural disadvantages experienced by members of the community (NASASV, 1998).²⁷³

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 are often unaware of the services available. Without the possibility of outreach work, the 'accessibility' of services is severely compromised.²⁷⁴ This Workbook aims to build the capacity of service providers to understand and support the complex needs of this client group in the face of widespread under-resourcing.

A proportion of women accessing services for mental health issues end up with diagnoses that do not take into account the traumatic impact of childhood abuse. Whilst medical and other allied health professionals cannot be expected to 'know'

if a disclosure has not been made, it is necessary for professionals to keep these issues on their 'radar', and adopt a model of trauma-informed care (Complex PTSD & BPD, section 2.2).

Principles of access to all members of the community must embody physical and geographic access (including meeting the needs of those in rural, regional and remote areas); as well as culturally appropriate advertising and information dissemination. Nor should any financial barriers exist or barriers to psychological access due to associated stigma, inappropriate values or philosophy of management.²⁷⁵

An example of such barriers for women with disabilities was highlighted by the National Committee on Violence against Women (1993).²⁷⁶ 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.

Equity implies the fair treatment of all service users, a just allocation of resources and positive discrimination towards those facing additional barriers to services (NASAV, 1998).²⁷⁷

Service provision must respect the cultural context of adult survivors, taking into account race, ethnicity, and language, age, gender, sexuality, intellectual and physical ability.²⁷⁸

In 2001, Weeks focused on whether Indigenous 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.²⁷⁹

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.

People with childhood abuse histories access services from a wide diversity of government, Community Managed Organisations (CMO) 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; psychology or psychiatry referral through Medicare or private psychologists, psychotherapists and counsellors; private hospitals and survivor support programs.

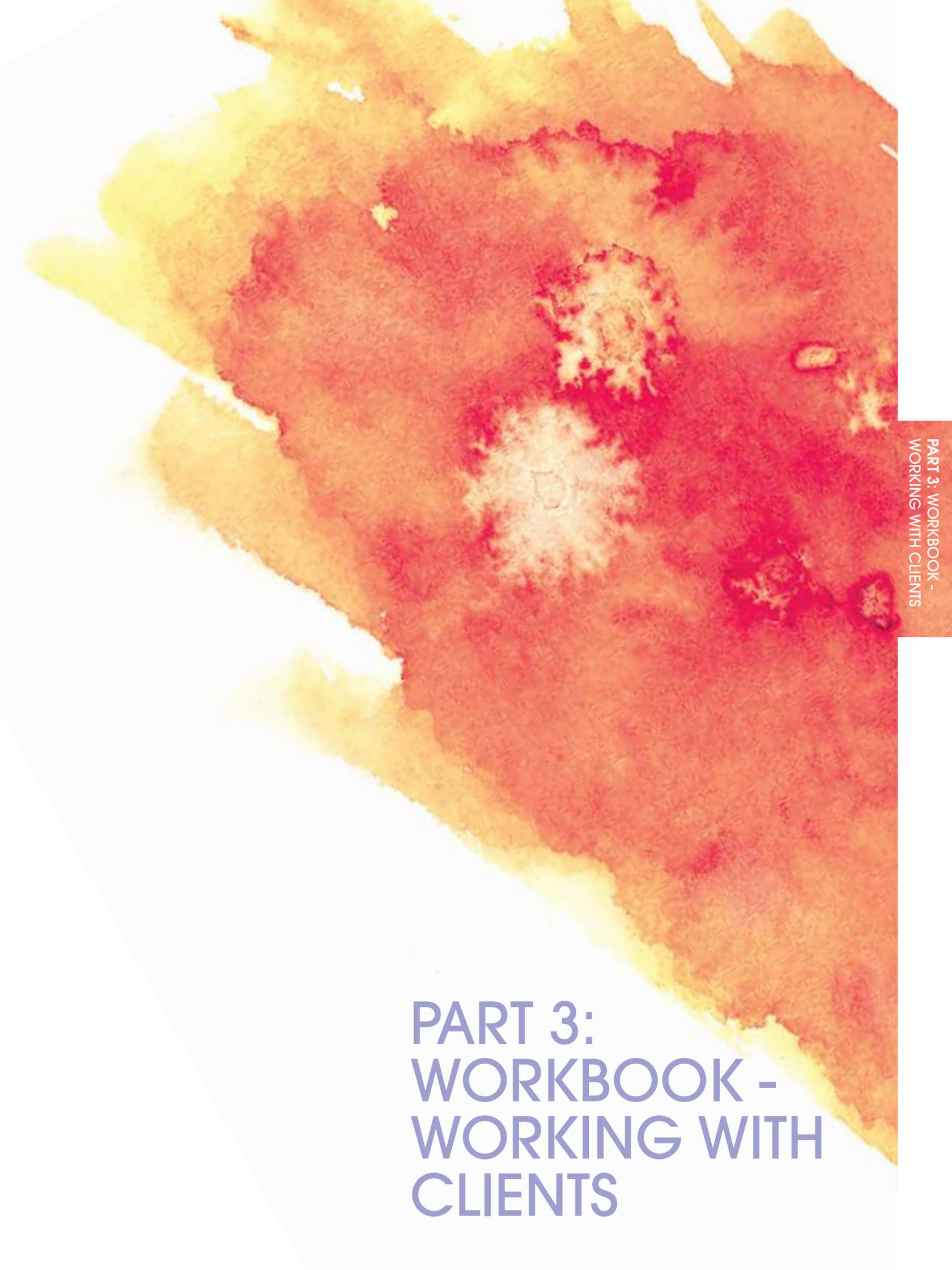
The report *Cultural Diversity and Services against Sexual Violence* (2002) noted that 4% of service users in NSW Sexual Assault Services in 1994 were immigrant women, in spite of constituting 15% of the population.²⁸⁰

These cultural and structural barriers are equally relevant to adult 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.²⁸¹

Providing services to survivors must include an acknowledgement that immigrant and refugee women may also be victims of torture and trauma prior to resettlement. 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 and emphasise the importance 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 not disclose episodes of extreme abuse such as CSA or torture.²⁸²



PART 3: WORKBOOK - WORKING WITH CLIENTS

By this stage, having read Parts 1 and 2 of this Information Resource Guide and Workbook you will have an understanding of the dynamics of childhood abuse, and can now make sense of the context in which problems affecting your clients may have developed.

Before moving on to this section that focuses on best practice guidelines, we encourage you to reflect on what you have learnt so far and complete a few exercises. These are reflective exercises for you to consider and evaluate your own work practices. These will help you process thoughts and reflections for discussion with colleagues or your supervisor.

By the end of Part 3 you will have covered topics mainly related to engaging with clients and understanding your own reactions to how clients may present. Part 4 provides a good overview of practical help for clients, including referral, access and continuity of care; and Part 5 relates to professional considerations such as self-care and supervision.

Part 6 is a comprehensive resource guide to services and information in NSW. All has been checked at time of press. We apologise for any inaccuracies that may have occurred thereafter. Please advise MHCC if any information has become obsolete, or of new resources that may be useful, so that it may be included in the next update.

EXERCISE 1

Identify some of the coping strategies you have observed in your clients

Identify some of the defence mechanisms your clients use

Which coping strategies are adaptive or maladaptive?

EXERCISE 2

Identify how the defence mechanisms your clients use may impact their lives

SCENARIO 1

Carolyn is 43 and was sexually abused by her uncle and grandfather when she was in her early teens. In her late teens she became very promiscuous, used hard drugs and was living on the streets, supporting her habit by selling herself. She has had a series of disastrous relationships with abusive men and is currently living with a 23-year-old unemployed labourer to whom she is pregnant. She is very upset because she thought he was different. Last week, when he got drunk he had slapped her around. She took out an AVO against him but she loves him and wants to get back with him.

What short-term strategies would you suggest for Carolyn?

What approach would benefit Carolyn in the longer term?

EXERCISE 3

Use the list below to identify which coping strategies your clients currently use and which strategies you might encourage clients to utilise in the future:

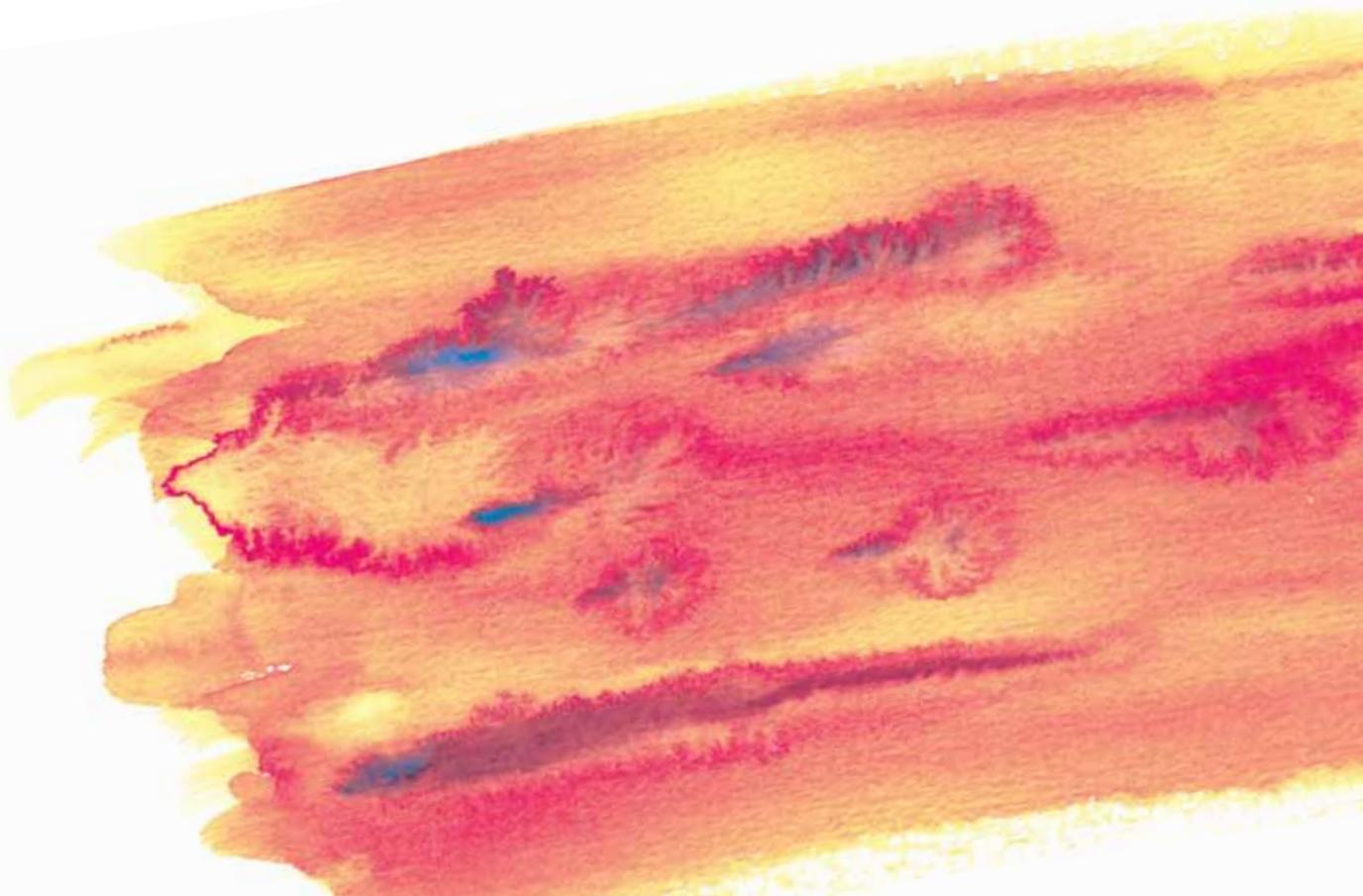
- Positive reinterpretation and growth
- Mental disengagement
- Venting of emotions
- Use of instrumental social support
- Active coping
- Therapy
- Denial
- Spirituality
- Humour
- Talk to friends
- Behavioural disengagement
- Restraint
- Use of emotional social support
- Substance use
- Acceptance
- Suppression of competing activities
- Mindfulness
- Exercise
- Planning

What other coping strategies have you encouraged your clients to use?

Source: Coates, D. & MHCC. (2009). *Working with Adult Survivors of Child Abuse*. ASCA Training Manual developed for MHCC.

CHAPTER 5: BEST PRACTICE GUIDELINES

- 5.1 The Recovery Orientated Approach
- 5.2 Myths, stereotypes, stigma and discrimination
- 5.3 Fundamental components of Recovery
- 5.4 Best Practice
- 5.5 Building rapport
- 5.6 Engagement skills
- 5.7 Interview skills used in conducting an assessment
- 5.8 Gathering information
- 5.9 Empowerment, self-efficacy and collaboration
- 5.10 Communicate and sustain respect and hope
- 5.11 Setting boundaries
- 5.12 Confidentiality
- 5.13 Consent
- 5.14 Disclosure



5.1 THE RECOVERY ORIENTATED APPROACH

RESPONDING HOLISTICALLY

Research has identified 'evidence-based' practice as the approach to service delivery which includes offering a range of flexible 'holistic' services. Community Managed Organisations 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).²⁸³

A rehabilitation/recovery orientated assessment is holistic and begins with the assumption that people with mental health issues are experts on their own recovery and that they have learned much in the process of living with and working through these problems. The emphasis is on identifying a range of client needs, working with diversity and working collaboratively with clients, their families and other agencies (Draper et al., 2007).²⁸⁴

EXERCISE 4

Reflect on what in your experience, constitutes 'best practice' when working with clients who have disclosed as survivors.

5.2 MYTHS, STEREOTYPES, STIGMA AND DISCRIMINATION

There is an assumption in society that people who have been abused in childhood are 'damaged' and not capable of living a normal life. On the contrary, many survivors manage to live their lives and succeed in a range of professions and all strata of society. In so doing, they show great strength and courage. Despite the impacts of childhood abuse, adult survivors resist the effects in many ways, and find strategies to help with healing and developing a new sense of self.²⁸⁵

Some adult survivors living with mental illness regularly identify that stigma and discrimination impacts on their ability to recover and lead a fulfilling life. Attitudes in the community are supported by ignorance, prejudice and discrimination, and are perpetuated when represented in the media in ways that engender fear and blame. People with mental illness are often discriminated against and are treated differently, socially excluded, and have access to fewer opportunities.²⁸⁶

Common misperceptions that contribute to the stigma of mental illness:

- That people with mental illness are dangerous. For example, in the media and movies people with mental illness are often portrayed as being violent and dangerous. Around 20% of Australians experience a mental disorder at some time in their life but studies suggest that only a small proportion of violence in society

is attributable to mental illness (up to 10%). In fact, violence is more closely correlated with the sex of the offender (i.e. male) and drug or alcohol use than with mental disorders (Paterson et al., 2004).²⁸⁷

- That all people who experience mental illness fit into one stereotype and are the same.
- That people who experience mental illness are unfit to work.²⁸⁸

Stigma can:

- Contribute to self-blame.
- Make a person feel socially alienated. This means that people who live with mental illness may find it harder to marry, to have children, to maintain employment and have a social life. People may lose contact with family, friends and social groups as a consequence.
- Discourage a person from seeking help. They may anticipate that people may not understand their symptoms and so be hesitant to seek treatment, often because of the negative attitudes they have experienced towards mental health issues.
- Be in the form of public stigma and self-stigma. Public stigma is the reaction that the general public has to people with mental illness. Self-stigma is the negative view that people who live with mental illness have of themselves because of their mental illness. This happens when a person is fearful of discrimination as a result of mental illness, and may make a person hide their illness to influence the impression they make on others. Negative emotions which people feel can harm self-esteem and confidence, and include shame, embarrassment, alienation and fear.
- Affect friends and family of those who experience mental illness.
- Lead to discrimination in the workplace and community, and also impact on securing safe and suitable accommodation.
- Hinder recovery.²⁸⁹

Stigma is reinforced by:

- The media
- Public attitudes and stereotypes
- The community by the use of discriminatory terms such as “psycho,” “schizo,” “nut” and “crazy.”²⁹⁰

Source: NSW CAG (2009). *Challenging Stigma and Discrimination*. Website. Available: http://www.nswcag.org.au/page/challenging_stigma_discrimination.html

EXERCISE 5

Reflect on what you believe are the myths; stereotypes; labels; and discrimination that adult survivors of child abuse may be subject to and consider how this may affect how you work with clients:

Think about the following clients you may engage with in your workplace that may have been stigmatised or experienced discrimination:

1. An adult woman with a diagnosis of Borderline Personality Disorder
2. A homeless young man
3. An Aboriginal woman with a severe alcohol addiction
4. A man with anger management issues
5. A seemingly overanxious pregnant woman.

What ideas, thoughts and words spring to mind surrounding these 5 cases?

1. _____

2. _____

3. _____

4. _____

5. _____

Have you had some discriminating thoughts about a client?
How did this affect your work?

SCENARIO 2

Dale is a 28-year-old Aboriginal petrol-sniffer who has been in and out of jail since he was 14 for theft, breaking and entering. He comes from outside Tennant Creek but now lives on the streets in Redfern. He left school when he was 14 and has never worked. His Dad who died 3 years ago from alcohol-related complications had beaten him and his brothers and sisters. The one brother with whom Dale was living had committed suicide a couple of months earlier. Dale does not trust anyone and especially whites.

How will you work to win his trust?

What judgements may prevent you from helping Dale as best you might?

How would you work through these discriminatory thoughts?

5.3 FUNDAMENTAL COMPONENTS OF RECOVERY

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

The US Department of Health and Human Services,
Substance Abuse and Mental Health Services Administration. (2006).
National Consensus Statement on Mental Health Recovery.

The *National Consensus Statement on Mental Health Recovery* notes the following 10 fundamental components of recovery:

1. **Self direction**
Consumers are the lead agent. They control, make choices and determine their own path of recovery. They define their goals and how they will reach them.
2. **Individualised and person-centred**
This concept recognises strengths-based approach in that we all have unique strengths and resilience and we all have the experience of our individual life journeys.

3. Empowerment

Consumers have the right to choose from a range of options and to participate in decisions made. Empowerment is seen as essential in allowing an individual to control their life.

4. Holistic

Holistic recovery takes into account all aspects of one’s life. This includes one’s physical, spiritual and emotional needs as well as connection to community.

5. Non-linear

This principle means that there is not a step by step approach to recovery—rather the process is based on the growth of an individual, where setbacks are seen as a normal part of the process and a learning process.

6. Strengths-based

The recognition of one’s capacities: talents; protective factors; coping abilities; resilience and the use of these strengths in the recovery process.

7. Peer support

The role of mutual support is a principle of recovery—the sharing of knowledge, skills and social support.

8. Respect

The concept of respect includes the elimination of discrimination and stigma and the social acceptance and appreciation of consumers.

9. Responsibility

Responsibility emphasizes the personal responsibility that consumers carry in the recovery process.

10. Hope

Hope is the message that people can and do overcome barriers that confront them. Hope is often the change agent of the recovery process.



EXERCISE 6

What components of recovery practice do you use in your work?

What components, if any, do you feel that you have not used in your work to date that might be particularly helpful with survivor clients?

Recovery is the journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness; and living well despite limitations resulting from the illness, its treatment and personal and environmental conditions.²⁹¹

Queensland Health. (2005). *Sharing the Responsibility for Recovery*.

5.4 BEST PRACTICE

Adults Surviving Childhood Abuse (ASCA) has conducted a review of the literature pertinent to 'best practice' for working with adult survivors of child abuse. The findings of empirical studies as well as guidelines established by clinicians experienced in working with survivors have been considered.

ASCA recommends the following 'best practice' guidelines for front-line workers whose clients who may have disclosed as survivors or that the worker may consider at risk:

1. Provide a safe place for the client
2. Ensure client empowerment and collaboration
3. Communicate and sustain hope and respect
4. Assess needs
5. Facilitate appropriate pathways for referral
6. Facilitate disclosure if client indicates a desire to disclose, without overwhelming the client (within the scope of organisational policy and procedure/job role)
7. Be familiar with a number of different therapeutic tools and models for referral purposes
8. Have a broad knowledge of risk minimisation strategies and provide the client with information and education
9. Teach clients adaptive coping strategies (i.e. teach clients self-care, distress tolerance strategies and arousal reduction strategies)
10. Teach clients interpersonal and assertiveness skills i.e. advocacy.

EXERCISE 7

What might safety mean for a client who is an adult survivor?

5.5 BUILDING RAPPORT

Building a trusting relationship with a survivor of childhood abuse can be very challenging, as those who have been repeatedly hurt in interpersonal relationships have acquired a range of ways to guard against future harm. Survivors of child abuse are often vigilant, cautious, suspicious and/or angry.

“The man who abused me was my favourite swim coach, I worshipped him and he abused my trust. Every man in a position of authority since then has been a potential abuser, my enemy. Mum did not believe me when I told her, so every woman is complicit in the abuse, waiting to do me over. Why should I trust you?”

Survivors may instinctively be secretive, untrusting and unwilling to open up to a worker early in the relationship. Survivors of childhood abuse explain that it takes time to believe that it is safe to reveal their feelings honestly and develop a trusting relationship with a worker (Draper et al., 2007).²⁹² Workers need to be patient with survivor clients and allow them to develop trust, at their pace.

EXERCISE 8

What are some of the challenges to developing safety and rapport that you may face when working with survivors of childhood abuse?

What are some of the strategies that you use to build rapport with clients?

SCENARIO 3

Suzie, a 45-year-old barmaid was put in foster care after her mother died when she was 3. She had a series of placements, the last was when she was mid-teens, during which 5 years the father of the house repeatedly sexually assaulted her and threatened her with a knife. She has travelled continually never settling in any one place for long. She is seeing you after having been admitted to hospital with a drug overdose. She has seen lots of case workers and counsellors over the years but feels they have done her more harm than good.

How will you work to build rapport with Suzie?

What will you do if she threatens not to continue accessing your service?

Suzie calls you saying she has had enough. She is going to end it. What do you do?

ACTIVE LISTENING SKILLS

Despite all the barriers, many adult survivors of childhood abuse find sharing their traumatic experiences cathartic and talking to a helper can be the first step in their recovery journey. The relationship of trust and safety that a survivor develops with a helper is central to this process.²⁹³

Workers who listen to a survivor, ask clarifying questions; do not challenge what a survivor says, or ask for details, often are able to help a survivor make the most progress towards establishing their needs. **It is best not to offer opinions.**²⁹⁴

Active, direct participation in validating a survivor's perceptions, feelings, and experiences, in addition to acknowledging the information being shared, and checking to make sure it is appropriately understood, are all important parts of helping a survivor express what she needs from your service. Often, simply repeating what your client has said helps to validate thoughts and feelings in ways that may have never been validated before. It sounds very simple, and yet it can be a powerful way to engage with a client (Walker, 1994, van Loon & Kralik, 2005a).²⁹⁵

Source: Coates, D. & MHCC. (2009). *Working with Adult Survivors of Child Abuse*. ASCA Training Manual developed for MHCC.

5.6 ENGAGEMENT SKILLS*

Community services workers can build more effective working relationships with people with mental illness (“consumers”) and their families and friends (“carers”) through the application of interpersonal communication skills and processes.

The essential communication skills include:

1. **Building rapport** – That is establishing a harmonious connection with someone over a period of time.
2. **Exchanging information** – It is important that both sides have sufficient information to meet their own needs. For the community services worker this will usually include seeking background information from file notes etc.
3. **Active listening** – This is not simply hearing the words that someone says to you. It involves the listener participating in what is being said, i.e. hearing the words, understanding the meaning and providing feedback.
4. **Questioning** – There are two basic types of questions: closed and open, both have their uses in working with clients.
5. **Responding appropriately to all situations** – This will often be defined in organisational guidelines and procedures.
6. **Encouraging storytelling** – Getting the person to tell their story is a way of exploring consumer needs and wants.
7. **Facilitating resolution of issues through conflict resolution**
8. **Defusing potentially difficult situations** – This involves the use of calming techniques.
9. **Negotiating** – Negotiation is an everyday event although there are times when we approach it more formally with consumers, carers, colleagues and managers.
10. **Reflecting on your own communication skills** – Seek feedback on the effectiveness of your communication skills.

A further word about interviewing/questioning:

Closed questions require a specific, factual answer for example:

- How long have you operated this machine?
- How often should you make entries in your logbook?

Open questions are exploratory and anticipate more complex information, explanations or opinion. Useful open questions that could be used as triggers for discussion include:

- Could you explain what you mean by...?
- Can you give an example of that?
- So, what would happen if....?
- Tell us more about why that wouldn't work?
- What's the difference between...and...?
- How would you go about doing that?
- Why would it be important to do that first?

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* This information and the two exercises in this section have been adapted from the “CommunityMindEd Mental Health Promotion and Suicide Prevention Resource for VET Teachers of Community Service.” Commonwealth of Australia 2005

5.7 INTERVIEW SKILLS IN CONDUCTING AN ASSESSMENT

Interviewing is an essential skill for community services workers. The following are some guidelines that may assist in conducting interviews with people with a mental illness and their family/friends:

1. **Prepare for the interaction** – Identify the purpose of the interview and the required outcomes. Review relevant reports and file notes. Note areas where you want additional information from the client. Write out the broad questions you want to ask. Identify and invite others such as carers, family or friends. Let them know the purpose of the interview.
2. **Set the atmosphere** – Create a safe place. Choose a location free from interruptions and hold all calls. Arrange a casual seating arrangement. Use round table or chair settings to denote equality. Ensure that appropriate accommodations are made for people who have special needs. Have water available.
3. **Establish rapport** – Welcome the client and any others by name and be relaxed and friendly.
4. **Set the agenda** – Thank them for coming and re-state the purpose. Describe the interview process to them and ensure they understand. Allow them to negotiate changes to the process if they wish. Let them know you will be taking notes.
5. **Conduct the interaction** – Go through each of the questions allowing time for thoughtful responses. Use active listening and response techniques to clarify and elaborate.
6. **Take notes** – This will help you ask follow-up questions and recall specifics later. Note key words/phrases — your notes need not be verbatim.
7. **Maintain control** – If the conversation gets off-track, ask a specific question that will bring the interview back to the subject.
8. **Allow silence and be patient** – The person may need some time to put his or her thoughts together to provide specific answers to your questions.
9. **Summarise the interview** – When you have completed all the questions summarise the main points and read out any conclusions or decisions that have been made. Check that everyone agrees and ask if there is anything else to be said or discussed. Allow time for this and add these comments to your notes.
10. **Identify next steps** – Having conclusions or decisions is not enough. The next steps and/or a follow-up needed should be discussed.
11. **Close the interview** – Thank everyone for coming. Show them out.
12. **Complete your file notes and reports** – Immediately write up file notes, reports, and diary entries; and develop a follow-up action plan and implementation dates.

5.8 GATHERING INFORMATION

During the process of gathering information about clients, **which is a client-driven process** (that should not be initiated or forced by a worker) it is important to develop a management plan that realises a client's personal goals and needs.

With regards to the above, strategies to achieve this include:

- Provide a safe space
- Give time

- Assure confidentiality and privacy
- Active listening
- Build rapport
- Empathy.

(Sections 5.4–5.14)

EXERCISE 9

Reflect on what information you might need to assess the needs and goals of a client attending your service?

(i.e.: safety; psychosocial supports; health; mental health (clinical, therapeutic); housing; legal; employment; education and training; employment; DOCS).

5.9 EMPOWERMENT, SELF-EFFICACY AND COLLABORATION

The concept of empowerment is linked to those of self-efficacy and collaboration. A client's sense of collaboration often results in clients engaging more positively with services and in more effective outcomes (McKeel, 1996; Miller 1995).²⁹⁶

Self-efficacy relates to the judgements and beliefs a person has about their ability to act in a given situation, to be actively involved in the process, contents and outcome or goals of an intervention (Bandura, 1997).²⁹⁷

*... the more people bring their influences to bear on events in their lives, the more they can shape them to their liking. By selecting and creating the environmental supports for what they want to become, they contribute to the direction their lives take.*²⁹⁸

Bandura, A. (1997). *Self-Efficacy: The exercise of self control*. Freeman & Company, NY.

Adult survivors characteristically were taught to dismiss their needs and attend to another's demands. It is critical in working with adult survivors to respect and acknowledge survivors' capacity to lead their recovery journey and become managers in the process.²⁹⁹

Based on their study with (female) survivors of child sexual abuse, van Loon and Kralik, (2005a) developed the following 'best practice' guidelines in terms of 'control and empowerment':

- Survivors of childhood abuse need to know that their wishes matter and that they can choose

- It is always important to respect the survivor's choices regarding her/his recovery
- That there will be no invasion or incursion of any of their personal boundaries
- They can leave at any time if they want/need to (without fear of reprisal or recrimination)
- Workers should never force help on survivors. (Sometimes the survivor is not ready to talk about what happened. The survivor may need to feel, or may need to remain numb for the present)
- When uncertain about what the survivor wants from you and your service ask what sort of support she/he thinks might be most helpful
- Always ask before touching a client and avoid touching unless clearly appropriate
- It is almost always damaging when a helper insists that he/she knows what the survivor needs, better than the client does
- It is important to work to empower the survivor to play an active role in her/his own decision-making, and role model how this is done
- Help a client to define their own goals and discuss ways to action their choices.³⁰⁰

EXERCISE 10

What role do empowerment, self-efficacy and collaboration play in the work that you do?

Can you think of an instance where you made a decision on behalf of a client (with the exception of suicide or self-harm)?

What were the outcomes of this decision?

5.10 COMMUNICATE AND SUSTAIN RESPECT AND HOPE

Respect is a vital part of the Recovery Oriented model (section 5.3). Recovery is a personal journey that is unique to an individual, but common elements include hope, respect, social inclusion and equality.

A worker's respect for the client is conveyed in many ways, including:³⁰¹

- Forms of address
- Respect for confidentiality
- Punctuality
- Sensitive use of language
- Admitting when you have made a mistake or do not know something
- Assuming that the client's point of view is as valid when different from the worker's own perspective
- Respecting cultural and religious differences, age and sexuality.

Helping professionals who work with survivors serve as trustees for survivors' future possibilities. In our words, actions, and body language, we communicate hope. While it's important to empathise with the survivor's current hurt and despair, it is important to hold onto visions of the survivor's potential future self (Saakvitne et al., 2000).³⁰²

EXERCISE 11

How might you convey respect and hope to an adult survivor who has an alcohol problem and has lost custody of her children?

It is critical that in building rapport and using all the skills outlined in Engagement Skills (sections 5.6–5.10) that a worker role models skills with the client. Important to this is the setting of boundaries.

5.11 SETTING BOUNDARIES

Boundaries are a crucial aspect of any effective client-worker relationship. They set the structure for the relationship and provide a consistent framework for working with a client.

Boundaries are guidelines that are based on the basic principles of a code of ethics.

Adapted from Corey (2004) the following briefly outlines five principles in counselling which equally apply to allied professionals:

- **Beneficence:** accept responsibility for promoting what is good for the client with the expectation that the client will benefit from the work you do together
- **Non-maleficence:** “doing no harm”. Avoid at all times, (even inadvertently) any activities or situations with the client that could cause a conflict of interest
- **Autonomy:** your responsibility is to encourage independent thinking and decision-making, and to deter all forms of client dependency
- **Justice:** commitment to provide an equal and fair service to all clients regardless of age, gender, race, ethnicity, culture, disability and socio-economic status
- **Fidelity:** being honest with clients and faithfully honouring commitment to the client’s progress

The confusion caused by boundaries is best described by Corey (1996) as a continuum, ranging from disengagement (rigid, inflexible boundaries and guidelines) to enmeshment (flexibility to the point of diffusement) with a large grey area in between that is notoriously ambiguous and dependent upon the worker, the situation and the client’s changing needs and circumstances.³⁰³

To be an effective helper one cannot disengage from the client to the extent that you cannot empathise with the client. However, empathising does not include physical contact, engaging socially with them as a friend or accepting gifts. Ambiguous boundaries often arise in the caring professions, but strict responsibilities apply in relation to their duty to inform clients of the limitations on client confidentiality. Such information forms a large part of informed consent and informed consent is a fundamental client right.³⁰⁴

EXERCISE 12

What ethical policies and procedures does your organisation have in relation to setting boundaries?

What do you do when a client brings you a gift of a box of chocolates or a book?

What do you do when a client brings you a gift that they have made like a jar of jam or a piece of pottery?

5.12 CONFIDENTIALITY

Confidentiality means the restriction of access to personal information to authorised persons only. The following Acts relate to the privacy and confidentiality of clients in community service-related agencies: ³⁰⁵

- Health Administration Act 1982 NSW
- Public Health Act 1991 NSW
- Health Records and Information Privacy Act 2002 NSW
- Privacy and Personal Information Protection Act 1998 NSW

EXERCISE 13

What ethical policies and procedures does your organisation have in relation to confidentiality?

Unless a disclosure leads you to believe the person is at risk of immediate harm to self or others, do not share information with others. It is appropriate to disclose information in some circumstances. These are:

1. When an individual consents to the disclosure
2. When the individual is less than 16 years of age and the information is disclosed for the purpose of notification to the child's parent, guardian or other
3. When the worker believes that failure to disclose will place the person at risk of harm or death. Disclosure is justified to avoid risk
4. When the worker considers failure to disclose will place members of the public at serious risk of harm or death. Disclosure is justified to avoid risk
5. When there is a need to consult a colleague or supervisor.

RIGHTS OF CONSUMERS

Consumers' rights include the following:

1. The right to privacy
2. The right to access all information about themselves by the service
3. The right to confidentiality and information on when there will be a need for disclosure
4. The right to complain about the service they are receiving
5. The right for their views to be taken into account in the planning and evaluation of the service
6. The right to be made aware of the standard of service which they can expect
7. The right to be informed about the expectations and rules of the service
8. The right to be involved in discussions about their assessment and support plan.

Source: MHCC LDU Responding to Suicide and Self-Harm.
071003_MHCC RSSH Learner Guide V7.1 Copyright © MHCC

5.13 CONSENT

In a crisis (for example in an emergency department) a health provider must take reasonable steps to ensure that a consumer understands key aspects of any treatment suggested before asking for agreement. This is called 'consent'. To comply with this requirement in the NSW *Mental Health Act 2007*, a health care provider must provide enough information to allow the consumer to make informed decision about the treatment. If a consumer agrees to treatment once they have understood this information, this is called 'informed consent' (MHCC, 2010).³⁰⁶

The information should include how the treatment will be given, possible benefits and effects of the treatment, and risks related to the treatment, including possible side-effects of medication and risks to physical health. If your client is under a Community Treatment Order (CTO) they should also be informed as to the different opportunities as to where they might receive treatment, i.e. in their home or at a facility (MHCC, 2010).³⁰⁷

Despite this legal obligation to inform a consumer, in a crisis it may not be possible for someone to absorb and understand the information or give informed consent. However, assumptions should not be made that a person does not have capacity. This is an integral part of best practice: self-direction; respect and responsibility.

In a crisis situation, ask the client to work with you to make things safer. If the individual must be contained to achieve safety, encourage the client's help and participation. It is always important to say what you are going to do before you act and to ask if a client can do it themselves. (For example, if you wish to call the Acute Mental Health Team; a medical practitioner; a relative or friend or your supervisor you would need to tell the client what is happening). The more you name what is happening and invite the client's collaboration towards achieving safety, the more you differentiate the present from past abuses of power.

After a crisis intervention, there should always be a debriefing with the client to discuss what was helpful and what could have been done differently.

EXERCISE 14

Can you identify what might be barriers that prevent survivors seeking help?

Can you identify what might be barriers to disclosure for clients?

SCENARIO 4

A client presents at your service and appears to be having a crisis (e.g. a psychotic episode; has become dissociative or is under the influence of drugs). You know her, and that she has a drug problem and is in a domestically violent relationship. She wants you to call her partner rather than the Mental Health Acute Care Team.

What do you do?

5.14 DISCLOSURE

BARRIERS TO DISCLOSURE

Trauma can prove extremely difficult to express in language as traumatic amnesia may mean that experience may not be recognised for what it is, or the abuse occurred when the individual was a child who was pre-verbal.

Research shows that a less developed trauma narrative hinders recovery from trauma (Amir, Stafford, Freshman, & Foa, 1998).³⁰⁸ During states of high arousal

(such as danger) the area of our brain responsible for speech becomes inhibited. This results in a diminished capacity for language in certain situations. The act of expressing feelings into words and constructing narratives of experiences enable emotional regulation, the integration of neural networks of emotion and cognition, and the experience of a coherent sense of self (Cozolino, 2008).³⁰⁹

Survivors of childhood abuse commonly experience self-blame. As children they characteristically believe that they are in some way responsible for the abuse, perpetuated by perpetrators and carried into adulthood. If they had not done something 'wrong' the abuse would not have occurred. This rationalisation helps the survivor retain the illusion that she has the power and control to not be hurt again (Walker, 1994).³¹⁰

Shame and guilt also contribute to the difficulties survivors experience seeking or accepting help. Because they were blamed for the abuse, survivors may experience guilt and take on the idea that they 'asked for it', 'invited it' or 'deserved it' (van Loon & Kralik, 2005a).³¹¹

Perpetrators are likely to have 'groomed' or coached a child into secrecy, and experiencing the pain and shame about the abuse may lead survivors to maintain their silence about the abuse. They may fear that no one will believe them; that their account of the abuse will be dismissed as a fabrication or an exaggeration. Similarly they may have experienced rejection and negative responses from caregivers and the system after a disclosure (whether as a child or adult) fuelling fears of further punishment and victimisation.

Some survivors 'have no voice' and need to feel empowered to disclose. They may fear that disclosing will cause them to be pathologised by clinicians; and become vulnerable to further punishment (i.e. having their children taken away because they are thought to be mentally ill).

Survivors may feel especially confused and shamed if some aspects of the abuse felt enjoyable, exciting and sensually stimulating. In addition, ambivalent emotions of love for the perpetrator and hatred for what they have done may also inhibit access to help (van Loon & Kralik, 2005a).³¹²

EXERCISE 15

Have clients told you about recalling memories after some sensory or situational 'trigger'? (For example: something that they remembered as true such as: images, sensations, feelings).

Have clients voiced a desire to disclose but not done so or expressed reticence or fear?

HOW TO FACILITATE DISCLOSURE

NEVER urge a client to disclose. If a client chooses to disclose you should be prepared to facilitate the disclosure.

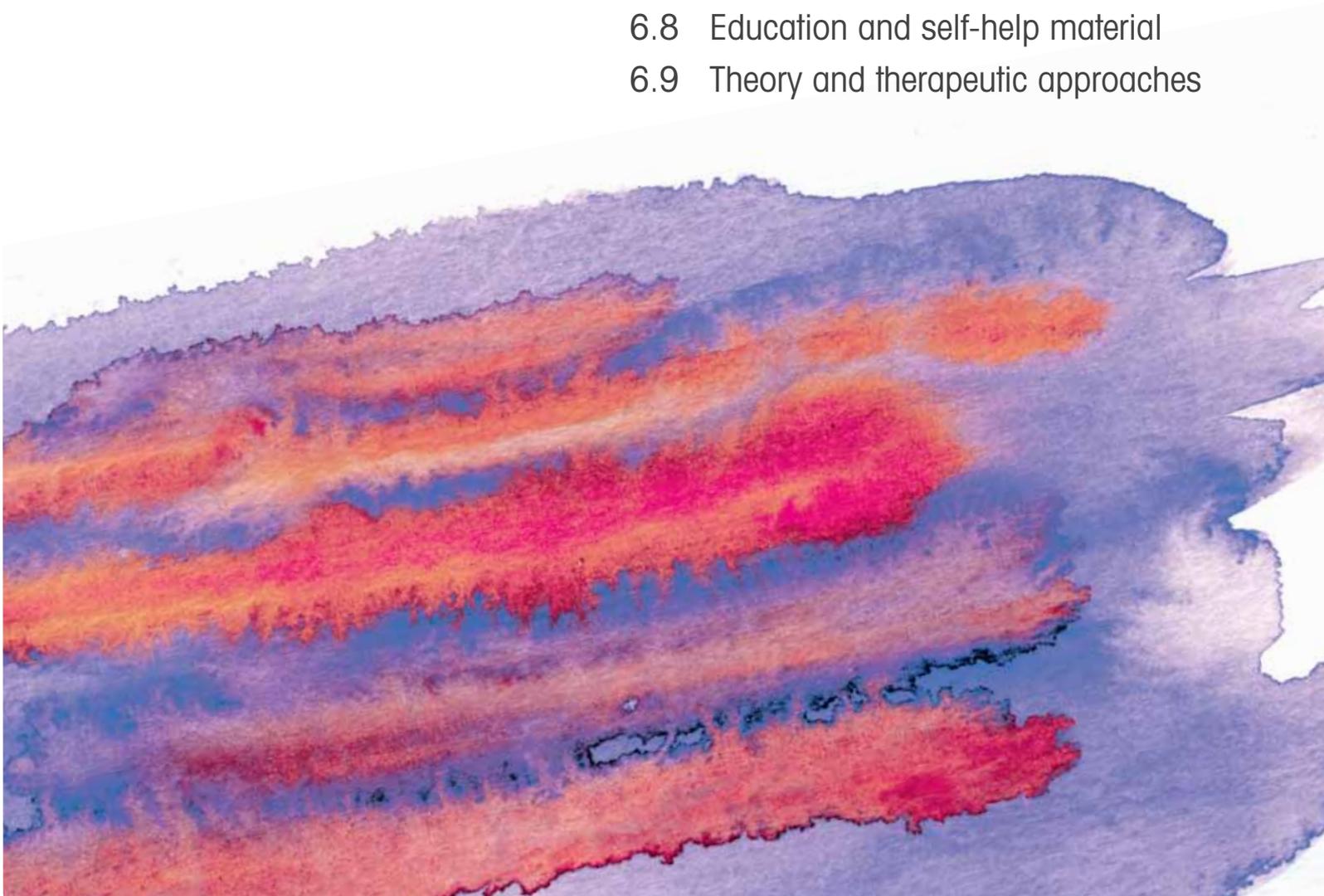
van Loon & Kralik (2005a) developed best practice guidelines around facilitating disclosure of child sexual abuse based on survivors' recommendations.³¹³ Survivor participants explained that they feel safe enough to disclose their abuse to a helper when the helper:

- Is approachable and understanding
- Has an open, honest and transparent professional agenda
- Is an interested and engaged professional
- Provides a supportive safe environment
- Is willing to listen non-judgementally to disclosure of child abuse
- Receives the client's story in a calm manner — does not dramatise or treat the story as 'unspeakable'
- Maintains confidentiality.

Source: van Loon & Kralik (2005a). In: Coates, D. & MHCC. (2009). *Working with Adult Survivors of Child Abuse*. ASCA Training Manual developed for MHCC.

CHAPTER 6:

- 6.1 Referral alternatives
- 6.2 Better Access to Psychological Services
- 6.3 Access to Allied Psychological Services through the MBS Scheme
- 6.4 Better outcomes – Access to Psychological Services (ATAPS) through Medicare
- 6.5 Community services
- 6.6 Continuity of care
- 6.7 Care Coordination
- 6.8 Education and self-help material
- 6.9 Theory and therapeutic approaches



6.1 REFERRAL ALTERNATIVES

It is important in referring clients to other professionals and services that you have an overview of the theory, models, and therapeutic approaches that are used by health professionals who work with survivors of childhood abuse, so that you can refer appropriately.

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 therapeutic process (section 6.9).

EXERCISE 16

How does your organisation partner with both internal and external agencies?

(For example: case review; case conferences; interagency meetings; personal networking research; supervision; peer support).

In some cases you may have the option of referring to Clinical Services (e.g. crisis teams; GPs; Community Mental Health Services etc.).

Particularly in regional, rural and remote areas, your alternatives may be more limited and you may need to refer to clinical services through a GP or psychiatrist using the Better Access Medicare Benefits Scheme.

6.2 BETTER ACCESS TO PSYCHOLOGICAL SERVICES

HELPING A CLIENT ACCESS APPROPRIATE THERAPEUTIC REFERRAL MEDICARE BENEFITS SCHEMES (MBS)

Since stage one of the Reframing Responses Project in 2006, an initiative has been established by the Commonwealth to provide improved access to mental health care through psychology services in the community through Medicare.

'Better Access' is a referral pathway to psychiatrists, psychologists, social workers and GPs who are accredited under the scheme, through the Medicare Benefits Schedule (MBS) initiative.

Medicare rebates to patients with a 'mental disorder' can receive individual allied mental health services. Unfortunately these benefits are generally limited to short courses of six individual sessions per calendar year. Many survivors of childhood abuse need to engage in long-term therapy. Whilst for some this intervention may be helpful, short-term engagement may represent re-victimisation and abandonment to a vulnerable client.

Rebates for these services are available to patients who have been referred by a medical practitioner managing the patient under a GP Mental Health Care Plan; a psychiatrist's assessment and management plan; or on referral by a psychiatrist or paediatrician.

Allied mental health services that can be provided under this plan include Group Psychological Therapy services by eligible clinical psychologists, and Focussed Psychological Strategies services provided by eligible psychologists, social workers and occupational therapists. At the end of each course of treatment, the allied health professional reports back to the referring medical practitioner on the patient's progress and the referring practitioner assesses the patient's need for further services. A further six sessions may be approved.

6.3 ACCESS TO ALLIED PSYCHOLOGICAL SERVICES THROUGH THE MBS SCHEME

A gap payment is often required representing the difference between the practitioner's fee and the Medicare rebate. This may limit access to services for clients who cannot afford to pay. A client needs to know that they have to pay the difference. As few private practitioners bulk bill, a client will need to claim the rebate from Medicare.

By collaborating with a GP or community service provider a worker can ensure that consumers may access services in the most useful way. The consumer can then make choices about how to receive care and treatment. Referral to a professional should be considered in the light of the assessment and the particular needs and goals for the client (section 5.7).

A client who cannot afford to pay up front should inform the referring practitioner (i.e., the GP) to refer them to health professionals who bulk bill. Access to health professionals is severely limited in some areas (especially in rural or remote locations, where the client is unable to access transport).

For further information the Australian Psychological Society has a fact sheet on the Medical Benefits Scheme (MBS) from a consumer's perspective.
Available: www.psychology.org.au/Assets/Files/Medicare_Fact_Sheet1.pdf

6.4 BETTER OUTCOMES – ACCESS TO PSYCHOLOGICAL SERVICES (ATAPS) THROUGH MEDICARE

GPs and other clinicians can refer patients with diagnosed mental disorders to Allied Health Providers via the ATAPS programs. ATAPS programs are run by most NSW Divisions of General Practice. These programs have been designed to meet local needs and vary in their referral processes and eligibility criteria.

For further information on a program in a specific area refer to your local Division of GPs. <http://www.gpnsww.com.au/about-us/nsw-divisions-of-general-practice>

Medicare will pay for access to psychological services through the Access to Allied Psychological Services (ATAPS) (up to 12 visits a year). ATAPS enables GPs under the Better Outcomes in Mental Health Care (BOiMHC) program to refer people to allied health professionals who deliver focused psychological approaches to treatment. In addition, eligible patients will also be able to claim for up to 12 group services (involving the same reporting and practitioner assessment processes as for the individual services) in a calendar year. Allied health professionals include psychologists, social workers, mental health nurses, occupational therapists and

Aboriginal and Torres Strait Islander health workers with specific mental health qualifications.

To access this service a client will need to be referred through a GP and referral is discretionary. The initial process takes some time. GPs will require advance notice to access psychological services through ATAPS and clients will need to organise a longer appointment and wait for approval of the mental health assessment and mental health plan. The initial appointment is likely to be within a couple of weeks but this will depend on the waiting list at the time.

Because of the fixed budget, the ATAPS program can deliver a limited number of services. As there is no patient charge for these services, only patients on low incomes who are unable to pay any gap fee for MBS services from private psychologists or clients referred for group programs are eligible.

6.5 COMMUNITY SERVICES

In some instances a community worker may decide that it is more appropriate to refer a client to a variety of other clinical and support services in the community, for example: Acute Mental Health Teams (crisis teams); Community Mental Health Units; specialist community managed programs such Women's Health/ Counselling Centres; Drug and Alcohol Services; supported accommodation; HIV; or to GPs, Private Psychologists and Psychiatrists. In regional, rural and remote areas, alternatives may be limited and a GP or Online Counselling Service may be all that is available.

Note: This Workbook provides an extensive referral guide to community services. Please refer to Part 6, Ch 9).

6.6 CONTINUITY OF CARE

Continuity of care is a continuous relationship between a consumer and an identified health-care provider.

As a consumer's health-care needs over time can rarely be met by a single professional, multi-professional pathways of continuity exist to achieve both quality of care and consumer satisfaction.

It is critical that workers provide continuity of care. When referring a client, it is necessary to consider the diversity of services which can be coordinated to provide holistic care and support.

6.7 CARE COORDINATION

Care coordination is a process that links clients with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the client and provide them with optimal health care.

Care coordination often is complicated because there is no single entry point to multiple systems of care, and complex criteria determine the availability of funding and services among public and private payers.

Centralised approaches to reform of mental health services implemented over the past 15 years in Australia often fail to achieve the widely shared aim of comprehensive, integrated systems of care. Investment to date has focused on the development and integration of specialist mental health services and primary medical care. Whilst some progress has been made, substantial inadequacies remain in the comprehensiveness and care coordination received by people affected

by mental health problems, particularly in relation to social and psychosocial interventions.

This may prove to be a real challenge when working with clients presenting with complex needs. Mitchell (2007) suggests that inter-sectoral collaboration that includes a diverse range of non-medical primary health and social care services is one of the most fundamental remaining challenges facing mental health system reform (MHCC, 2009).³¹⁴

6.8 EDUCATION AND SELF-HELP MATERIAL

In the literature, much attention is paid to the cognitive and emotional processing of traumatic memories. Psycho-education is an important aspect of trauma therapy. Health professionals can assist survivors by providing accurate information about the nature of trauma and its effects, and by working with the survivor to integrate this new information and its implications into his/ her overall perspective (Briere & Scott, 2006).³¹⁵

Rothschild (2003) in *The Body Remembers* explains that by understanding how the brain and body process, remember, and perpetuate traumatic events, the client learns how to regulate affect and pain.³¹⁶

Recommending books and articles about survivor issues may aid healing. However, it is important to consider a number of factors. Some material may be 'triggering' for some clients and it is important to discuss how clients can pace and protect themselves.

Some clients may have difficulty reading and feel pressured or panic when reading is suggested, further exacerbating their lack of self-esteem. Audio or DVDs are suggested as alternatives.

DISCUSS INDIVIDUAL LEARNING STYLES WITH CLIENTS

What have they read already? How did the reading affect them? Encourage them to notice their reactions, thoughts, and feelings, and to stop reading if they feel distressed or over-stimulated. Give clients the opportunity to discuss what they have read and their response to the material.³¹⁷

SURVIVOR RECOMMENDED SELF-HELP BOOKS:

Matsakis, A. (1996). *I Can't Get Over It: a Handbook for Trauma Survivors*. (2nd ed) Oakland: New Harbinger Publications ISBN: 157224058X

Miller, A. (1995). *The drama of Being a Child: the search for the true self*. Time Warner Books UK ISBN: 1860491014

Kelly, L. (1998). *Surviving Sexual Violence*. Oxford, Blackwell.

Kezelman, C. (2010). *Innocence Revisited: a tale in parts*. Jojo Publishing.

Schiraldi, G. R. (2000). *The Post Traumatic Stress Disorder Sourcebook: A Guide to Healing, Recovery and Growth*. McGraw-Hill ISBN: 0737302658

van Loon, A. M. & Kralik, D. (2005) . *Reclaiming Myself after Child Sexual Abuse*. Available: http://www.catherinehouse.org.au/Portals/0/pdf/research_projects/WomensResource_FINAL_Oct05.pdf

FOR MEN AND BOYS

Lew, M. (2004). *Victims No Longer: The classic guide for Men Recovering from Sexual Child Abuse*. 2nd ed. Perennial Currents. ISBN: 006053026X

Lew, M & Hoffman, R. (2000). *Leaping upon mountains: Men Proclaiming Victory over Sexual Child Abuse*. North Atlantic Books ISBN: 155643345X

Satuallo, J., Russell, R. & Bradway, P. (1987). *It Happens to Boys Too..*, Elizabeth Freeman Center. ISBN: 0961861800

6.9 THEORY AND THERAPEUTIC APPROACHES

EXERCISE 17

Are particular models emphasised in your agency?

Are certain models used for working with survivors of childhood abuse?

The following is a selection of the modalities used most commonly in government and community services nationally and internationally. They may be used integratively or as specific therapeutic models:

PHARMACOTHERAPY (MEDICATION)

Medication can minimise the anxiety, depression and insomnia often experienced by adult survivors. 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 an individual's greater participation in psychotherapy.³¹⁸

COGNITIVE BEHAVIOURAL THERAPY (CBT)

Cognitive Behaviour Therapy (CBT) often used in conjunction 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)*.³¹⁹

Working with survivors of childhood abuse the CBT model usually focuses on the 'here and now' rather than revisiting the trauma itself. It 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.³²⁰

CRITIQUE OF THE MEDICAL MODEL

Many professionals consider CBT as a 'band aid' that fails to address the impact of long-term trauma experienced by most survivors of childhood abuse. Many practitioners feel that concepts of 'faulty thinking and patterns of behaviour' are inappropriate to this client group. Whilst some clinicians 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 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.³²¹

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 the client's subjective experiences.³²²

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 childhood abuse. Other models are commonly criticised on the basis that there is little or no quantitative evidence base, and that the qualitative evidence is subjective.

Since the 1960s, anti-psychiatry and 'post-psychiatry' movements have critiqued hierarchies of power (Bracken & Thomas, 2001).³²³ 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). It provides practical and effective coping techniques. Whilst this modality has its critics, such as Peter Fonagy (1999),³²⁴ it is 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.³²⁵

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.³²⁶

*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).*³²⁷

DBT is usually at least a one-year 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,³²⁸ whilst undergoing individual therapy and receiving support (between sessions) via telephone consultations. This model is costly and primarily only available in Australia in the private sector, although a few agencies have begun piloting it in the public sector.

SCHEMA THERAPY

Schema Modes are the moment-to-moment emotional states and coping responses (that we all experience) that often lead to an overreaction to situations, or lead people to act in ways that produce negative outcomes. Often schema modes are triggered by life situations that people are oversensitive to (i.e. our 'emotional buttons'). In therapy, a new experience of relating enables the development of a secure attachment and, consequently, a more coherent sense of self.

The four main concepts are: early maladaptive schemas, schema domains, coping styles and schema modes. The goals are to: help clients stop using maladaptive coping styles and get back in touch with their core feelings, to heal their early schemas, to learn how to move out of self-defeating schema modes as quickly as possible and eventually to get their emotional needs met in everyday life.

NARRATIVE THERAPY

Johnella Bird (2000:2004) has been extremely influential in the development of narrative therapy in the context of trauma. Her approach is underpinned by feminist and narrative practices which focus on the power dynamics in a therapeutic relationship.³²⁹

Narrative Therapy for survivors is usually understood in the context of a feminist framework, with a strong belief in a collaborative approach. The objective is to utilise the relationship to enable the client to acquire agency in all areas of their life. 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).*³³⁰

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.*³³¹

In line with recovery principles, Narrative Therapy promotes a core belief that individuals are: *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).*³³² By understanding and re-authoring, healing can occur through particular 'tellings' and 'retellings'. 'Narrative practices' are an evolving process in which people engage their own individual manner.³³³

NARRATIVE 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).³³⁴

Group therapy particularly suits survivors 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 shares.

Telling one's story (the 'trauma narrative') and directly facing the grief, anxiety, anger, betrayal and guilt 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).³³⁵

TRAUMA-BASED APPROACH

A Trauma-Based Approach: *serves to normalise symptoms and behaviours that have traditionally been pathologised and viewed as examples of personal and social deviance (Bloom, 1997, p. 70). A trauma-informed approach primarily views the individual as having been harmed by something or someone: thus connecting the personal and the socio-political environments (Bloom, 1997, p. 71). This framework expects individuals to learn about the nature of their injuries and to take responsibility in their own recovery (Bloom, 2000).³³⁶*

THE SELF-TRAUMA MODEL

Briere (1992:1996) integrated facets of trauma theory in addition to CBT, behavioural therapy and self-psychology into this model. 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.³³⁷*

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).³³⁸

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).³³⁹ The intentions of the model are represented in terms of the specific process, content and goals of abuse-relevant psychotherapy.

CONSTRUCTIVIST SELF-DEVELOPMENT THEORY (CSDT)

Developed by Saakvitne et al. (2000) Constructivist Self Development Theory (CSDT) is a model based on a trauma framework and assumes that just as people can harm each other deeply, so can they help each other profoundly. CSDT assumes that childhood abuse interrupts the normal development of a person's ability to

identify and regulate their feelings. This is similar to other trauma frameworks that emphasise the importance of learning ‘feeling skills’ (Briere, 2004, Linehan, 1993a). CSDT focuses on hope, connection, collaboration, respect and empowerment.³⁴⁰

In essence, CSDT:

- Emphasises the healing power of the relationship between the health professional and the survivor
- Views symptoms as adaptations
- Posits that crises can best be managed and eventually reduced through the development of ‘feeling skills’
- Views the person of the therapist as an essential part of the healing process
- Expects the work to have an impact on the therapist that parallels the impact of trauma on the survivor.

SOMATIC TRAUMA THERAPY

Somatic Trauma Therapy, developed by Babette Rothschild, is an integrated treatment model that draws from the most relevant theory and techniques for the understanding and treatment of trauma and PTSD. It is an eclectic approach in which the practitioner continually evaluates the most effective interventions for trauma related problems (Rothschild, 2003).³⁴¹

Somatic Trauma Therapy is an integrated system of psychotherapy and body-psychotherapy that continues to evolve as new theory and techniques emerge in the field. It addresses all aspects of the trauma’s impact (on thinking, emotions and bodily sensations) bringing them into sync, and relegating trauma to its rightful place in the past.³⁴²

The concept proposes that the ‘The Body Remembers’ and becomes a resource in the treatment of trauma. By understanding how the brain and body process, recall and internally perpetuate traumatic events once the trauma is over, the client learns how to regulate affect and pain (Rothschild, 2003).³⁴³

SURVIVOR THERAPY

Survivor Therapy is a treatment approach developed by Lenore A. Walker designed to help survivors of man-made traumas. It is based on the treatment approaches of both feminist therapy theory and trauma theory, integrating the consistent philosophies and borrowing techniques from each. On the basis of an analysis of power, survivor therapy treats victims of violence by focusing on their strengths, despite their injuries. It takes into account the gender based impact of trauma within the woman’s socio-political, cultural, and economic context, emphasising respect and empathy for all women who have been abused.

Survivor therapy explores the coping strategies adopted by victims and builds on their strengths while exploring new ways of coping enabling victims to become survivors (Walker, 1994).³⁴⁴

POST-TRAUMATIC STRESS MODEL

The relationship between child sexual abuse 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).^{345 346 347}

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.*³⁴⁸ Herman (2002) writes that: *under conditions of chronic childhood abuse fragmentation becomes the central principle of personality organisation.*³⁴⁹

Fragmentation prevents the normal integration of knowledge, memory, emotional states and bodily experience which later manifests in mental health problems and difficult interpersonal and sexual adjustment in adulthood (Rieker & Carmen, 1986).³⁵⁰ This model has found strongest support in the observations of clinicians dealing with individuals with histories of severe and repeated abuse.³⁵¹

TRAUMAGENIC DYNAMICS

In the United States, Finkelhor (1987) proposed a less medicalised model for the mediation of the long-term effects of CSA. The model asserts that the attitude of the survivors to self and others is characterised by traumatic sexualisation which may lead to sexual inhibition, fears of intimacy, sexual precocity or promiscuity; and a sense of powerlessness which may lead to passivity and avoidance. It also asserts that a sense of stigma can lead to social withdrawal, guilt, shame, suicidality, and substance abuse; the sense of stigmatisation and betrayal causes a persistent suspicion of others, fear of intimacy, and vulnerability to later sexual abuse (Finkelhor, 1987).³⁵²

Whilst emphasising the psychological ramifications of the abuse, Finkelhor (1997)³⁵³ barely acknowledged the social dimensions. In the past twenty years attempts have 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).³⁵⁴

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.³⁵⁵

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 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).³⁵⁶

Nurcombe (2005) writes that the outcome of abuse is determined by complex and multiple transactions between moderating variables such as the abuse experience and events relating to the abuse such as disclosure or non-disclosure. The consequential impact 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).³⁵⁷

PSYCHODYNAMIC PSYCHOTHERAPY

Psychodynamic Psychotherapy works to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension. It has been used as the basis for many 'talking therapies' and counselling models.

It is a model of therapeutic endeavour in which the therapist creates a 'safe space' within which individuals 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).³⁵⁸

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.

Demonstrated to be valuable for people diagnosed with BPD, Stevenson and Mearns (1992) describe it as a 'relational framework' that includes self, other, transference, countertransference, idealisation, empathic attunement and emotional support.³⁵⁹

Transference is a phenomenon characterized by unconscious redirection of feelings from one person to another. In this a client may project the relationship of another onto the therapist.

Countertransference is defined as redirection of a psychotherapist's feelings toward a client or, more generally, as a therapist's emotional entanglement with a client. In such cases the client represents for the therapist an object of the past on to whom past feelings and wishes are projected.

THE CONVERSATIONAL MODEL

A model of psychodynamic psychotherapy devised by the English psychiatrist Robert Hobson (1985) and developed by the Australian psychiatrist Russell Mearns (1975:2004). It is a psychoanalytically oriented model based on a psychology of 'self' derived from developmental observations. Attention is directed to the "minute particulars" of the therapeutic conversation, elaborated by exploring concepts of self, boundary formation, the empathic mode of listening, subjective experience, the development of affect and use of language in development of self. Concepts of self are examined, using William James' (1980) definition of self as a subjective experience, the "stream of consciousness" involving a dual consciousness of I/Me.

PERSON-CENTRED HUMANIST PSYCHOTHERAPY AND COUNSELLING

'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).³⁶⁰

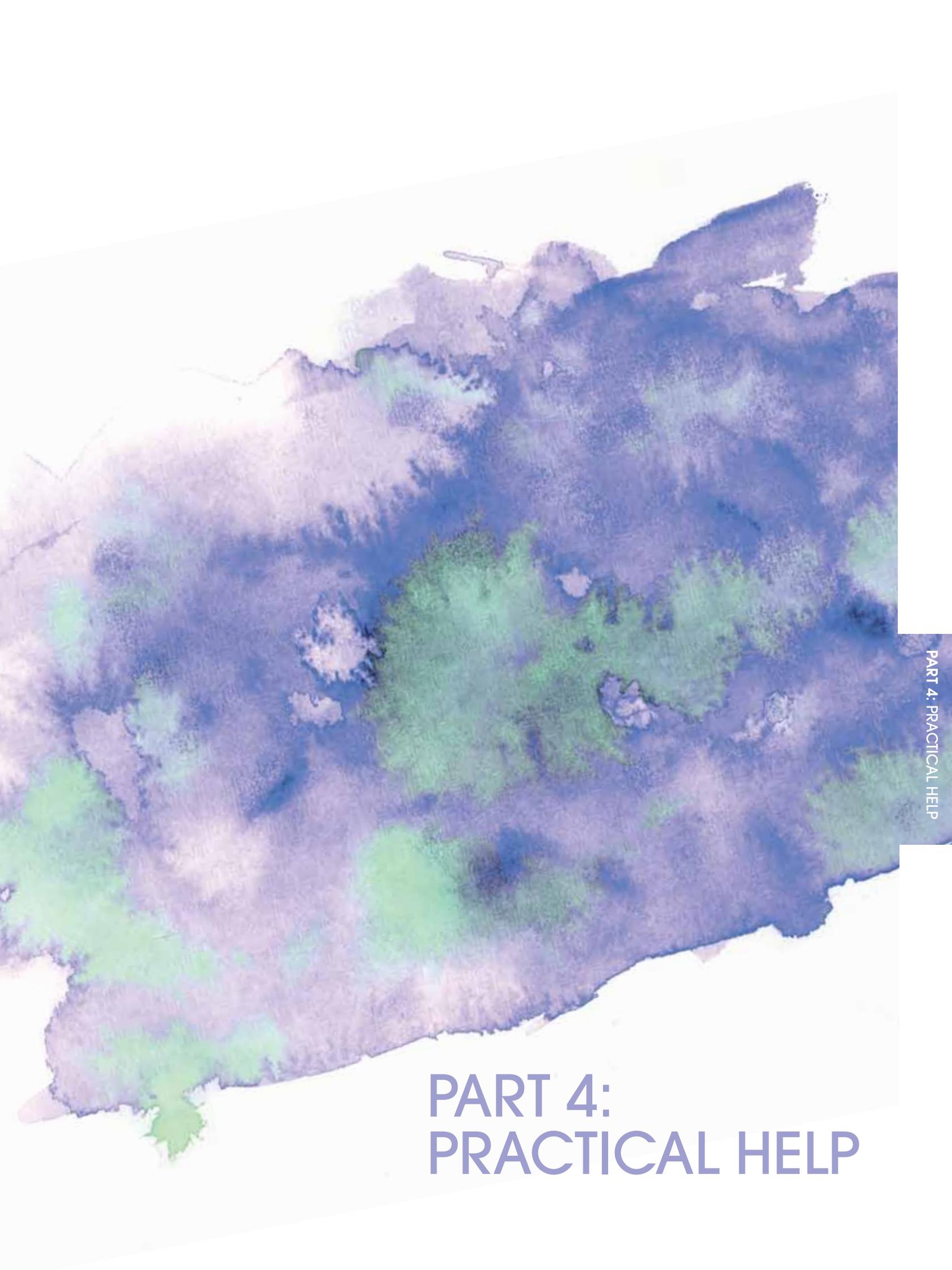
EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

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,³⁶¹ 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.³⁶²

EXERCISE 18

A client presenting at your service is known to regularly self-harm, has a chaotic lifestyle and regularly uses crystal methamphetamine. Nevertheless, she manages to hold down a job, and strongly indicates her desire to address her abuse-related issues.

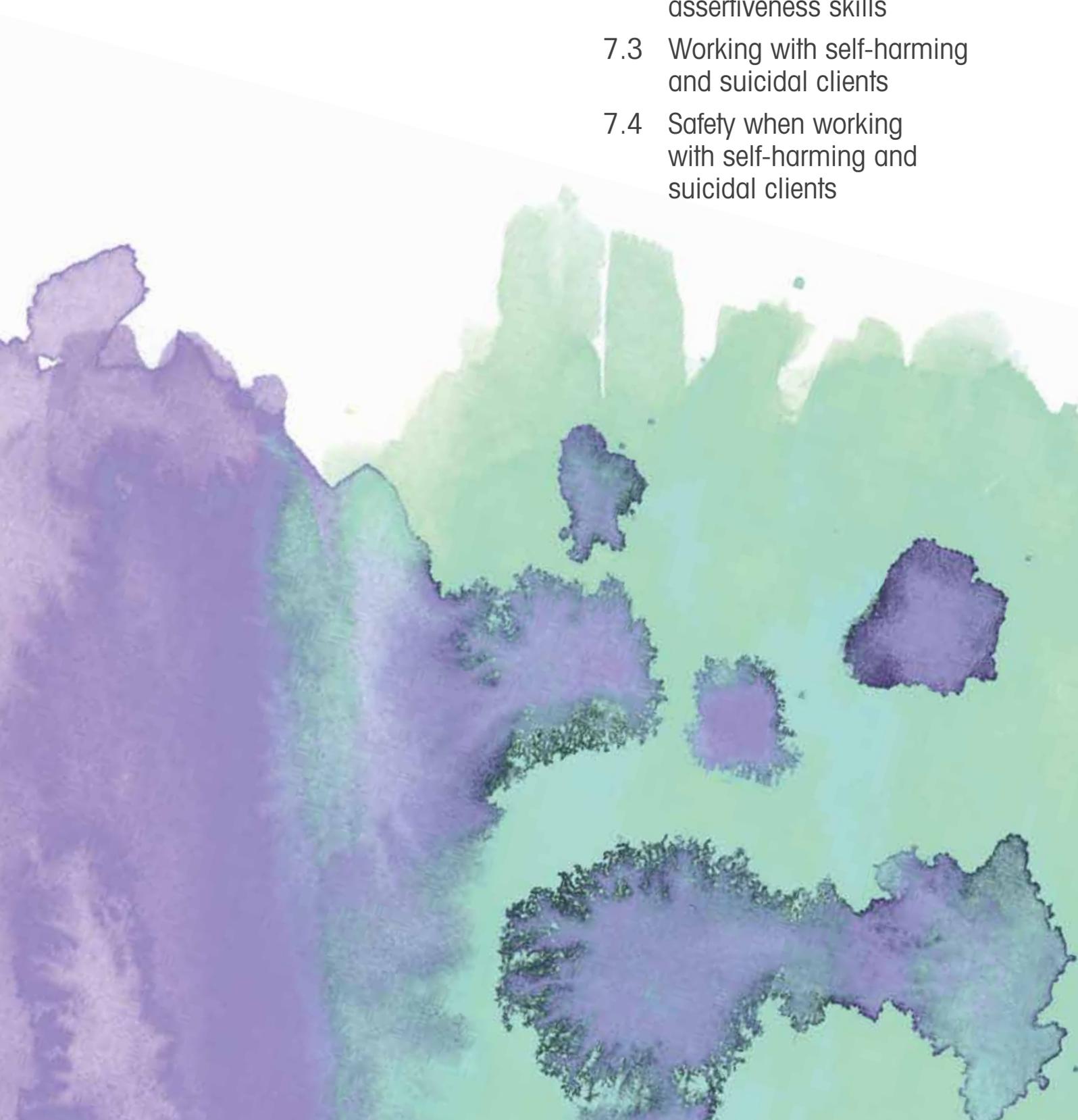
Consider the therapeutic model that might be appropriate to meet her need.



PART 4: PRACTICAL HELP

CHAPTER 7

- 7.1 Self-care strategies
- 7.2 Offer interpersonal and assertiveness skills
- 7.3 Working with self-harming and suicidal clients
- 7.4 Safety when working with self-harming and suicidal clients



7.1 SELF-CARE STRATEGIES

As discussed earlier (sections 3.2; 3.3; 3.4) coping mechanisms useful during childhood may no longer be constructive. In present life situations discuss more adaptive coping strategies with survivor clients.

A study by Harper et al. (2007) found clients rated professionals helpful when they could reinforce or offer strategies for managing the intense affect associated with traumatic childhood abuse.³⁶³

Research into the adverse impact of child abuse on brain development and hormone secretion, highlights the importance of engaging in self-care, and arousal-reducing activities. A range of interventions and skills which promote healthy functioning have been shown to normalise the nervous system and balance hormone levels. Clients can be taught more adaptive coping strategies, self-care strategies, distress tolerance strategies, and arousal reduction strategies.³⁶⁴

In: Coates, D. & MHCC. (2009).

Working with Adult Survivors of Child Abuse. ASCA Training Manual developed for MHCC.

OFFERING SELF-CARE STRATEGIES

Self-caring activities and learning how to soothe themselves emotionally are important skills for all survivors. Engaging in self-care activities can be especially challenging for survivors who may have never learned 'self-soothing' (other than with maladaptive strategies) or 'self-care'.

Neglecting, hitting, insulting or abusing a child, send a clear message to that child that they are without value or worth. Many abused children grow to adulthood believing that they do not deserve to experience love, care or warmth. Learning self-care can be a challenge for adult survivors of child abuse, since it requires survivors to develop a radically new understanding of themselves as human beings with the right to feel comfortable, safe and valued.³⁶⁵

To strengthen clients' sense of self-acceptance and self-care some of the following strategies can be recommended:

- Write a letter; journal
- Repeat affirmations ('I deserve to live'; 'I deserve to be treated kindly, with respect; 'I deserve to be loved')
- Remember that being treated badly in childhood was not fair and you deserve to be treated differently now
- Do something that makes you feel better about yourself: garden, help someone else; cook; be active; do something creative; dance; work on a charitable or political project.

Encourage clients to make their own list and choose at least one item from each area to work actively to improve upon.

In: Coates, D. & MHCC. (2009).

Working with Adult Survivors of Child Abuse. ASCA Training Manual developed for MCC.

EXERCISE 19

List under the following categories what self-care strategies you might encourage clients to utilise.

Physical

Psychological

Emotional

Spiritual

Life Balance

Many approaches to mental health treatment focus on changing distressing events and circumstances. They pay little attention to accepting, finding meaning for, and tolerating distress. Dialectical behavioural therapy (DBT) emphasises learning to bear pain with skills (Linehan, 1993b, p. 96).³⁶⁶

Distress tolerance skills have to do with the ability to accept, in a non-evaluative and non-judgemental fashion, both of oneself and the current situation. Although the stance advocated is non-judgemental, it does not embrace approval (acceptance of reality is not approval of reality). Distress tolerance behaviours are concerned with tolerating and surviving crises and accepting life in the moment (section 6.8 DBT).

Four sets of crisis survival strategies are taught: distracting, self-soothing, improving the moment, and thinking of pros and cons (Linehan, 1993b).³⁶⁷

Dialectical Behaviour Therapy is a three-pronged approach:

- Accepting clients as they are within a context of trying to teach them to change
- Supportive acceptance; validation

- Confrontation & change strategies (individual or group work towards emotion regulation, improved interpersonal effectiveness, distress tolerance, core mindfulness, self-management skills).³⁶⁸

Linehan, M. (1993b). *Skills Training Manual for Borderline Personality Disorder*. New York: The Guildford Press.

Survivor clients should be encouraged to identify and list strategies to use when feeling distressed.

THINKING PROS AND CONS

It might be helpful to encourage clients to make a list of the some pros and cons of *tolerating* distress (i.e. not acting impulsively):

- Focus on long-term goals, the light at the end of the tunnel. Remember times when you have tolerated your distress (without acting out, being self-destructive or acting impulsively) and the pain has ended.
- Think of the positive consequences of tolerating distress. Imagine in your mind how good you will feel if you don't act impulsively (Linehan, 1993b).³⁶⁹

Another list can be made of the pros and cons of *not tolerating* distress – that is, of coping by hurting yourself, abusing alcohol and drugs, or doing something else impulsive. Encourage clients to think of all the negative consequences of not tolerating their current distress, and acting impulsively (Linehan, 1993b).³⁷⁰

In: Coates, D. & MHCC. (2009).
Working with Adult Survivors of Child Abuse. ASCA Training Manual developed for MHCC.

OFFERING AROUSAL-REDUCTION TOOLS ('REDUCE THE PRESSURE')

Arousal-reducing tools can assist survivors in regulating their emotions. A state of hyper-arousal is a natural response to threat, and many trauma survivors remain in a constant state of alarm because fight or flight responses are repeatedly triggered (Giarratano, 2004b), often without evident purpose (Cloitre, Cohen, & Koenen, 2006).³⁷¹

A state of hyper-arousal may include feelings such as anger or anxiety.

A state of anxiety is common among trauma survivors because it is typically generated by experiences that are unpredictable, uncontrollable, or unfamiliar.

Symptoms caused by hyper-arousal include:

- Having a difficult time falling or staying asleep
- Feeling more irritable or having outbursts of anger
- Having difficulty concentrating
- Feeling constantly 'on guard' or like danger is lurking around every corner
- Over-breathing, hyperventilating
- Being 'jumpy' or easily startled (Giarratano, 2004a).³⁷²

OFFERING GROUNDING EXERCISES – AROUSAL-REDUCING STRATEGIES

Grounding involves detaching yourself from emotional pain by focusing on the outside world rather than what's going on inside you. It is useful for extreme emotional pain. Grounding exercises designed to distract can be helpful when attempting to reduce states of hyper-arousal (e.g. anger, anxiety).

You might like to encourage your clients to use some of the following examples:

Examples of mental grounding

- Describe your surroundings in detail, using all your senses—vision, hearing, smell, taste, and feeling
- Describe what you are doing, such as eating, walking, or driving, in detail
- Think of categories; for example, categorise shoes, hair, cars, or books
- Use imagery; for example, hop on a cloud and float away from your pain; put your pain in a bubble and let it float away
- Use a grounding statement, such as: ‘I am Jo’; ‘I am 23 years old’; ‘this is the present, and not the past’; ‘I am safe here’; ‘today is ...’
- Say the alphabet slowly
- Think of something funny.

Examples of physical grounding

- Rub your hands together—hard
- Press your heels into the floor, and notice how it feels
- Touch objects around you as you say their name, and explore them using all your senses
- Stamp your feet
- Change your posture to a more upright one
- Put your hands under running water
- Carry something small with you that grounds you, such as a rock or a piece of fabric.

Examples of soothing grounding

- Make encouraging statements to yourself, such as: ‘you can do this’; ‘just hang in there’
- Think of a place where you have felt calm and peaceful: remember everything about it, using all your senses
- Go to a safe place you have already created in your imagination: notice all the details in terms of environment, air temperature, shelter, other people there, animals, and so on
- Plan something nice for yourself, a walk, a good meal
- Think of people you care about; carry a photo or some other reminder of them with you
- Think of good things coming up in the next week or so
- As you breathe, on the exhale say something calming, such as ‘relax’ or ‘it’s OK’.

Suggestions to make grounding work well

- Practice the strategies
- Have a list of best grounding strategies somewhere handy (such as a note in a diary, or a note stuck in the car or on the fridge) to remind you to use them
- Start doing grounding exercises early in a distress cycle
- Rate your distress levels before and after grounding, so you can tell which strategies work best.

Source: Najavits, L. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guildford Press. Handout: ‘Using grounding to detach from emotional pain’:133–5).
Available: <http://www.ipcommunications.com.au/pdfs/cwsh08-handout-grounding.pdf>

OFFER MINDFULNESS STRATEGIES

Mindfulness is a form of self-awareness training adapted from Buddhist mindfulness meditation. It has been adapted for use in treatment of depression, especially preventing relapse and for assisting with mood regulation. It has been described as a state of being in the present, accepting things for what they are. It was originally developed to assist with mood regulation and relapse prevention in depression and has been found to have considerable health benefits.

You might like to do the following exercises with your client so that they can practice at other times.

One Minute Exercise:

- Sit in front of a clock or watch that you can use to time the passing of one minute. Your task is to focus your entire attention on your breathing, and nothing else, for the minute. Have a go—do it now.

Mindful Eating:

- This involves sitting down at a table and eating a meal without engaging in any other activities—no newspaper, book, TV, radio, music, or talking.
- Now eat your meal paying full attention to which piece of food you select to eat, how it looks, how it smells, how you cut the food, the muscles you use to raise it to your mouth, the texture and taste of the food as you chew it slowly.
- You may be amazed at how different food tastes when eaten in this way and how filling a meal can be. It is also very good for the digestion.

Mindful Walking:

- Using the same principle, while walking you concentrate on the feel of the ground under your feet, your breathing while walking. Just observe what is around you as you walk, staying IN THE PRESENT. Let your other thoughts go, just look at the sky, the view, the other walkers; feel the wind, the temperature on your skin; enjoy the moment.

De-stressing Exercise:

- Bring yourself into the present by deliberately adopting an erect and dignified posture
- Then ask yourself: "What is going on with me at the moment?"
- You simply allow yourself to observe whatever happens. Label any thoughts that you have and then leave them alone...just be prepared to let them float away. Attend to your breathing or simply take in your surroundings instead.
- Besides thoughts, there may be sounds you hear, bodily sensations that you are aware of. If you find yourself constantly elaborating on thoughts, rather than labelling them and returning to the neutral, remember to observe your breathing.
- When emotions or memories of painful events occur, don't allow yourself to become caught up by them.
- Give them short labels such as "that's a sad feeling", "that's an angry feeling" and then just allow them to drift or float away. These memories and feelings will gradually decrease in intensity and frequency.
- More importantly, you will begin to identify yourself as an objective observer or witness rather than a person who is disturbed by these thoughts and feelings. This requires practice but can then be used whenever you are stressed.

Associated Breathing Exercise:

- Stay with any distressing thoughts for a few moments, then as you let them float away you gently redirect your full attention to your breathing.
- Pay attention to each breath, in and out, as they follow rhythmically after one another. This will ground you in the present and help you to move into a state of awareness and stillness.

OFFER VISUALISATION AROUSAL REDUCING STRATEGIES

Encourage clients to experiment with a number of visualisations or distracting thoughts:

Other people's lives:

Observe what is happening around you. Look at people and try to imagine what kind of house they live in, whether they have any pets, what they do for a living, whether they would be easy to get along with or not, what kind of clothes they have on! before you know it, you will have lost your train of thought.

Objects around you:

Look at an object near you, and really observe it in detail. For example, look at a tree. Try to guess how old it is, who planted it, what it would feel like to touch it, smell it or climb it. Try to remember the last time you climbed a tree. Who were you with? What did it feel like up the tree? Would you ever consider climbing a tree again?

Picture yourself:

Look at a photograph of a favourite place or painting on the wall. Try to imagine the person who painted it. Try to imagine them painting it. Imagine yourself inside the picture or painting, examining it, touching things in the picture. What would you be able to hear, feel and smell if you were in the picture; what would be around the corner of the objects in the picture?

Lists:

Think of a girl's name that begins with each letter of the alphabet. Now try a food that begins with each letter of the alphabet. Remember the aim of the exercise is to concentrate on things other than worrying thoughts.

Trace the room:

Name the objects in the room. Start in one corner and label each thing that you see; go around the room until you reach the place that you started. Of course, you don't have to say the words aloud. When you've finished, try closing your eyes and saying the objects by memory.

Source: Coates, D. & MHCC. (2009). *Working with Adult Survivors of Child Abuse*. Training Workshop Manual developed for MHCC.

7.2 OFFER INTERPERSONAL AND ASSERTIVENESS SKILLS

Conflictual interpersonal relationships and impairment of the ability to assert oneself are of crucial importance for understanding the effects of child abuse on mental health outcomes. Research consistently shows that child abuse is linked to these difficulties for adult survivors.

In a study by Collishaw et al. (2007) almost half of those reporting abuse in adulthood showed significant abnormalities in interactions with peers in adolescence. At the same time, peer relationships in adolescence emerged as one of the strongest predictors of resilience within the abused group. This study found that only those individuals with good relationship experiences across childhood, adolescence and adulthood are likely to demonstrate resilience.³⁷³

Collishaw et al. (2007) explain that children who have experienced abuse are less likely to bring positive expectations or interpersonal strategies to a relationship. Instead they may see others as untrustworthy and unpredictable, and relationships as a potential source of conflict rather than a source of support and enjoyment.³⁷⁴

7.3 WORKING WITH SELF-HARMING AND SUICIDAL CLIENTS

Many survivors of childhood abuse injure their bodies in direct and indirect ways. In addition to cutting, burning, head-banging, hitting etc., self-harming behaviours include alcohol and drug addictions, and eating disorders. Alcohol and drug addiction often go hand in hand with unsafe behaviours (drink-driving, unsafe sex, dangerous drug deals, etc).³⁷⁵

Repeating trauma in violent relationships is another form of self-harm. All of these behaviours possibly represent the survivor's attempts to manage or eradicate feelings, prevent memories, or re-enact some aspects of the abusive experiences (Saakvitne et al., 2000).³⁷⁶

ASSESSMENT OF SUICIDE AND SELF-HARM – AREAS OF INQUIRY ³⁷⁷

Communication skills are critical when issues need to be raised in a manner that fosters the development of client engagement (see Section 5.8):

- Body-language, open and closed posture, safe environment etc
- Active listening, non-judgmental
- Paraphrase, summarise etc
- Use of silence
- Use of direct questions.

Some areas of inquiry in the assessment of moderate and superficial self-harm:

- History of self-harm—including lifetime and current frequency i.e. number of episodes or daily time spent, age of onset, course, longest period free of behaviour, change over time
- Motivation
- Impulsive or planned action
- Strength of urge, resistance to urge
- Success in controlling urge
- Emotional state before, during and after self-harm
- Temporal relationship to any suicidality
- Trigger events/factors
- Preoccupation with self-harm
- Use of drugs or alcohol before, during or after self-harm
- Family history of self-harm—may indicate biological predisposition or significant meanings of the behaviour for the client.

Source: MHCC LDU. (2009). *Responding to Suicide and Self-Harm*. 071003_MHCC RSSH Learner Guide V71.

EXERCISE 20

A client comes into your service in a state of hyper-arousal, she says that she wants to kill herself and starts to bang her head against the wall. What do you do?

PLAN OF ACTION IN AN EMERGENCY: (in no particular order)

- Immediate physical injury to an individual, be themselves or someone else, is an EMERGENCY requiring intervention
- Immediately call for assistance—know who to call
- Do not threaten or challenge the individual
- Do not attempt to disarm an armed individual on your own
- Give the person time to tell you their concerns
- Focus on the present rather than past issues
- Remain patient with the individual
- Keep your voice calm and even
- Explain to the individual your desire to help the individual with their issues, and acknowledge their distress
- Do not be threatening or aggressive

Source: MHCC LDU. *Responding to Suicide and Self-Harm*. 071003_MHCC RSSH Learner Guide V4. Copyright © MHCC

7.4 SAFETY WHEN WORKING WITH SELF-HARMING AND SUICIDAL CLIENTS

The most effective tool for achieving safety is our relationship with clients. However, there are times when we have to give safety precedence over these alliances. This might involve coercive practices which inevitably mean the polar opposite to safety for many adult survivors. It is important to work collaboratively with clients and staff and be specific about what will happen if there is a threat of suicide and a means to carry it out.

RESPONSE TO RISK

‘Empowering clients’ is especially hard when clients are in hospital, in great distress, asking us to protect them, or suicidal (Saakvitne et al., 2000). Self-injurious behaviours tend to make many of us want to take control and move to action.³⁷⁸

Traditional models of working with survivors of childhood abuse often emphasise control of unusual or dangerous behaviours that are deemed as ‘dangerous to self

or others' or 'out of control'. When control takes precedence over collaboration, treatment systems may use and overuse restraints (physical or chemical), locked doors, contracts, denial or privileges, and withdrawal of treatment. These programs unwittingly substitute control for change (Saakvitne et al., 2000).³⁷⁹

Many of our current practices around restraint, involuntary medication, and emergency room procedures create re-traumatising conditions (Saakvitne et al., 2000). More often than not, this re-traumatisation could be reduced or avoided if the client was consulted and included as much as possible.³⁸⁰

In the decision-making process, try to include your clients in the development of crisis response plans. Let your clients know what your responsibilities and limits are, and ask for their help to develop the best possible plan for helpful responses when they are in crisis. When a discussion about safety occurs in the context of a relationship, the discussion is less about rules and more about collaboration and cooperation (Saakvitne et al., 2000).³⁸¹

EXERCISE 21

Under what circumstances would you feel obliged to act with coercion?

Under what circumstances would you acknowledge client control?

What are your responsibilities?

Legally

Ethically

Organisationally

Interpersonally

Note: We recommend that you check what policies and procedures your organisation has in place with regards to OH & S and Duty of Care, and discuss these matters with your supervisor and colleagues.

EXERCISE 22

What strategies might your agency use when working with self-harming clients in regards to?

Physical safety

Management plans

Contracts

Appropriate referral

EXERCISE 23

How might responses and actions differ if a client who states the intention to overdose tonight, as compared to a client that regularly cuts and burns themselves?

EXERCISE 24

A client of your service, the mother of a young woman with intellectual disability contacts your service distressed and says that her other adult daughter has disclosed sexual abuse by a family member who has been invited for Christmas. She suspects that her sister was also abused.

How might you assist this client?



PART 5: PROFESSIONAL CONSIDERATIONS

CHAPTER 8

- 8.1 Reflective Practice
- 8.2 Supervision
- 8.3 Vicarious traumatisation
- 8.4 Managing vicarious traumatisation, stress and burnout
- 8.5 Helping carers and family members
- 8.6 Debrief



8.1 REFLECTIVE PRACTICE

Many workers reading this Workbook will regularly engage in supervision and reflective practice. Whilst this Workbook does not explore these matters in detail, we encourage all workers embrace reflective practice as part of their professional 'way of being.' Such practice is extremely helpful in working with the complex and often challenging situations which arise when working with adult survivors of childhood abuse.

Reflective Practice is a process that enables a person to examine the history, experience, values, knowledge, and cultural reference points they bring to an interaction and how these may impact on how they manage and perceive the same interaction from three dimensions (Schön, 1987).³⁸²

Reflection-in-action is defined by Schön (1987) as: *the ability of professionals to 'think what they are doing while they are doing it'*. He proposes this as a key skill and asserts that the only way to manage the 'indeterminate zones of (professional) practice' is through the ability to think on your feet, and apply previous experience to new situations. This is essential work of the professional, and requires the capability of reflection-in-action.³⁸³

EXERCISE 25

What is your understanding of practice frameworks?

Are you able to clearly articulate your practice framework?

If you feel unclear about these questions, you might like to discuss this with your supervisor and colleagues to learn more to assist you in the work that you do.

- Reflective practice is about exploring values
- Our values guide our work practice
- Our values assist us in the way we understand change and the circumstances around which change is possible
- Our values guide the interactions in which we engage
- It is always a good idea to stop and reflect on what our actual core values are so we can communicate these to others.³⁸⁴

RECOMMENDED REFERENCES:

- Argyris, M. & Schön, D. (1974). *Theory in Practice. Increasing professional effectiveness*. San Francisco: Jossey-Bass.
- Schön, D. A. (1973). *Beyond the Stable State. Public and private learning in a changing society*. Harmondsworth: Penguin.
- Schön, D. (1983). *The Reflective Practitioner. How professionals think in action*. London: Temple Smith.
- Schön, D. (1987). *Educating the Reflective Practitioner*. San Francisco: Jossey-Bass.

8.2 SUPERVISION

Supervision is perhaps the most important element in the development of a competent practitioner. The supervisory relationship should be a complex blend of professional, educational and therapeutic aspects. It is within the context of supervision that professionals develop a sense of professional identity and examine their own beliefs and attitudes regarding clients and their work (Corey, Corey, & Callanan, 2007).³⁸⁵

It is widely accepted that all professionals working in the mental health field, whether clinicians or not; whether experienced or just starting out, will benefit from having regular professional supervision. A supervisor acts in a mentoring role, providing support as well as information and guidance whilst maintaining best practice standards for client care and safety.

The work in which you engage may be emotionally draining at times. To avoid burn-out and to assist you in dealing with the issues that arise from client work that might trigger problems for you, Geldard and Geldard propose supervision is a critical component to staying safe and healthy and developing as a professional (2001).³⁸⁶

Many of us entered the mental health field in part because we recognised our own needs and wished to make a difference in the lives of others. Clients, too, have a need to have an impact upon us, to engage with us in meaningful ways. Sometimes this need is overlaid with a survivor's fear of harming us or being toxic to us. Often a survivor's need to matter to us is denied or unconscious (Coates, 2009).³⁸⁷

EXERCISE 26

Do you engage in regular supervision?

Is your supervisor your line manager or an external supervisor?

Think about the benefits and limitations of the model of supervision in which you engage.

What do you do after a critical event if your supervisor is not available?

EXERCISE 27

Can you describe in what way a client affected you both positively and negatively in the past?

Have you ever shared with a client how s/he has affected you?

Why or why not?

8.3 VICARIOUS TRAUMATISATION

Vicarious trauma is described as a transformation in a therapist (or other worker) as a result of working with clients' traumatic experiences. Pearlman and Saakvitne (1995) described it as follows:

The inner transformation that occurs in the inner experience of the therapist (or other professional) that comes about as a result of empathic engagement with clients' trauma material (p. 31).³⁸⁸

It is related to concepts such as 'emotional exhaustion', 'burnout', 'compassion fatigue', 'secondary traumatised' and 'counter-transference', but some key

differences exist between some of these concepts (see Dunkley and Whelan, 2006).³⁸⁹ It can also be expressed as 'feeling heavy', or when the work (or an aspect of the work) 'gets inside you'.³⁹⁰

Research indicates that service providers often find working with survivors of childhood abuse stressful because of the traumatic nature of the work and because of the way clients may conduct interpersonal relationships (Palmer et al., 2001).³⁹¹ The nature of the work is particularly stressful when it involves listening to detailed descriptions of very painful, often horrific events (Palmer et al., 2001). There is no doubt that hearing and thinking about certain stories one hears can continue well after the client has left.³⁹²

EXERCISE 28

List any reactions you have experienced as a result of working with traumatised clients.

EFFECTS OF VICARIOUS TRAUMA

Vicarious trauma is a cumulative effect of working with trauma, which can affect many aspects of a person's life. It may consist of short-term reactions, or longer-term effects that continue long after the work has finished. Some have even argued its effects are potentially permanent (Mouldern & Firestone, 2007, p. 68).³⁹³

Some effects of vicarious traumatisation parallel those experienced by the survivor. For example, vicarious traumatisation can lead to a person experiencing the symptoms of post-traumatic stress disorder (PTSD).

While the symptoms of trauma need to be recognised as culturally diverse and specific (Wasco, 2003), trauma reactions are generally divided into three categories:³⁹⁴

- *intrusive reactions*: dreams/nightmares, flashbacks, obsessive thoughts, physiological reactions and other persistent re-experiencing of the traumatic event;
- *avoidant reactions*: general numbing in responsiveness and avoidance (particularly of things related to the traumatic material); and
- *hyper-arousal reactions*: hyper-vigilance and difficulty concentrating.

Workers may also experience the following:

- anxiety
- depression
- de-personalisation
- feeling overwhelmed by emotions such as anger and fear, grief, despair, shame, guilt

Part 5: Professional Considerations

- increased irritability
- feeling of reduced personal accomplishment
- procrastination
- low self-esteem
- having no time or energy for self or others
- increased feelings of cynicism, sadness or seriousness
- an increased sensitivity to violence and other forms of abuse, for example when watching television or a film
- avoiding situations perceived as potentially dangerous
- feeling profoundly distrustful of other people and the world in general
- disruptions in interpersonal relationships
- sleeping problems and
- substance abuse.

Connected to these experiences, vicarious traumatisation may also involve a change in a person's beliefs about themselves, the world, and other people within it. This is known in the psychological field as changes in their 'cognitive schema', and may involve:

- feeling that the world is no longer a 'safe place' (for themselves and/or others)
- feeling helpless in regard to taking care of themselves or others
- feeling their personal freedom is limited and
- feeling alienation (that their work within the field of sexual assault sets them apart from others).

It is useful to state that vicarious trauma is just one way of conceptualising people's reactions to working in the field of trauma. It can be a useful way of conceptualising these reactions, because it can give legitimacy to people's experiences and recognises that many other people experience it. It is important not to 'pathologise' these reactions. In fact, all research on this subject points out that these reactions are normal human reactions to repeated exposure to distressing events.³⁹⁵

Vicarious traumatisation is a cognitive/ schematic theory of worker stress. Schemas include beliefs, assumptions and expectations about the self and world that enable individuals to make sense of their experience. Exposure to trauma can challenge and change specific schemas about the world and themselves (for both victims and workers). Vicarious traumatisation is an enduring cognitive consequence of being exposed to other people's traumatic experience and has significant impact on the worker's feelings, relationships and life.³⁹⁶

Common schemas affected by vicarious traumatisation are:

- Dependency/trust
- Safety
- Sense of loss of power
- Reduced self-esteem
- Intimacy
- Frame of reference
- Disruption in memory.

Note: A worker's experience may exactly mirror a client's experience.

STRESS AND BURNOUT

Stress and burnout are related but different. Stress is a set of psychological, physical and behavioural responses to work-related demands over a discrete or short-term period. Burnout is a form of chronic strain that develops over time in response to prolonged periods of high stress.³⁹⁷

BURNOUT SYMPTOMS ³⁹⁸

1. Emotional exhaustion: feeling overextended and drained of emotional and physical resources.
2. Depersonalisation: negative, detached or cynical view of one's work.
3. Reduced personal accomplishment: low sense of achievement, feelings of incompetence and low self-efficacy.

EXERCISE 29

How do you know if you are suffering from chronic stress or burnout?

STRESS AND BURNOUT CHECKLIST

Here are some early warning signs. Do you experience the following signs and symptoms of stress/burnout on a regular basis?

- Exhausted, tired and physically run down
- Feel annoyed or irritated towards co-workers
- Cynical and negative towards work
- Not caring about doing a 'good job'
- A sense of being besieged
- Losing your temper
- Frequent headaches and/ or gastrointestinal disturbances
- Weight loss or gain
- Difficulty sleeping
- Difficulty thinking logically and making decisions
- Inability to relax and concentrate (at home and/or work)
- Feeling weepy or tearful.

If you recognise 2 or 3 (or more) of these symptoms then you may be at risk of chronic stress and potentially burnout (Skinner & Roche, 2005).³⁹⁹

CONSEQUENCES OF STRESS AND BURNOUT ⁴⁰⁰

- Reduced organisational functioning: reduced job satisfaction, lower organisational commitment and increased turnover
- Worker health and wellbeing: depression, psychosomatic complaints and health problems
- Client outcomes: reduced client satisfaction.

Stress and burnout occur when there is an imbalance between job resources and demands.

8.4 MANAGING VICARIOUS TRAUMATISATION, STRESS AND BURNOUT

PREVENTION AND REDUCTION STRATEGIES

A variety of interventions are required to address stress, burnout and vicarious traumatisation. Solutions need to address both the individual worker who is stressed and organisational factors.⁴⁰¹

INDIVIDUAL STRATEGIES ⁴⁰²

- Learn stress management strategies
- Develop strategies to deal with a demanding workload such as realistic goal setting, scheduling regular rest breaks and daily activities that include a mix of high and low stress tasks
- Maintain a healthy lifestyle
- Maintain realistic expectations, boundaries and beliefs
- Recognise the struggle of competing demands: between home and work, client and self, organisation and individual
- Seek out a mentor or clinical supervisor
- Have a learning perspective – try to make improvements to the way you work over time.

SELF-CARE WORKSHEET ⁴⁰³

The following worksheet for assessing self-care is not exhaustive, merely suggestive. Feel free to add areas of self-care that are relevant for you, and rate yourself on how often and how well you are taking care of yourself these days.

When you are finished, look for patterns in your responses. Are you active in some areas of self-care but disregard others? Are there items on the list that make you think, "I would never do that"? Listen to your inner responses, your internal dialogue about self-care and making yourself a priority. Take particular note of anything you would like to include more in your life.

Rate the following areas according to how well you think you are doing:

3 = I do this well (e.g. frequently)

2 = I do this OK (e.g. occasionally)

1 = I barely or rarely do this

0 = I never do this

? = This never occurred to me

EXERCISE 30**Physical Self-Care**

- Eat regularly
- Eat healthily
- Exercise
- Get regular medical care for prevention
- Get medical care when needed
- Take time off when sick
- Get a massage
- Dance, swim, walk, run, play sports, sing, or do some other fun physical activity
- Take time to be sexual—with myself, with a partner
- Get enough sleep
- Wear clothes I like
- Take vacations
- Take day trips or mini-vacations
- Make time away from telephones
- Other: _____

Psychological Self-Care

- Make time for self-reflection
- Notice my inner experience—listen to my thoughts, beliefs, attitudes, feelings
- Have my own personal psychotherapy
- Write in a journal
- Read literature that is unrelated to work
- Do something at which I am not expert or in charge
- Attend to minimising stress in my life
- Engage my intelligence in a new area, eg go to an art show, sports event, theatre
- Seek support from others
- Be curious
- Say no to extra responsibilities sometimes
- Other: _____

Emotional Self-Care

- Spend time with others whose company I enjoy
 - Stay in contact with important people in my life
 - Give myself affirmations, praise myself
 - Re-read favourite books, re-view favourite movies
 - Identify comforting activities, objects, people, places and seek them out
 - Allow myself to cry
 - Find things that make me laugh
 - Express my outrage in social action, letters, donations, marches, protests
 - Other: _____
-

Spiritual Self-Care

- Make time for reflection
 - Spend time in nature
 - Find a spiritual connection or community
 - Be open to inspiration
 - Cherish my optimism and hope
 - Be aware of non-material aspects of life
 - Try at times not to be in charge or the expert
 - Be open to not knowing
 - Identify what is meaningful to me and notice its place in my life
 - Meditate and/or pray
 - Have experiences of awe
 - Contribute to causes in which I believe
 - Read inspirational literature or listen to inspirational talks, music
 - Other: _____
-

Workplace or Professional Self-Care

- Take a break during the workday
- Take time to chat with co-workers
- Make quiet time to complete tasks
- Identify projects or tasks that are exciting and rewarding
- Set limits with clients and colleagues
- Arrange work space so it is comfortable and comforting
- Get regular supervision or consultation

- Negotiate for my needs (benefits, pay raise)
- Have a peer support group
- Have balance within my work–life and workday

Overall Balance

- Have balance among work, family, relationships, play and rest

Other Areas of Self-Care that are relevant to me

Source: University of Ballarat. Available: http://www.ballarat.edu.au/aasp/student/sds/self_care_assess.shtml

ORGANISATIONAL STRATEGIES

There are a variety of strategies that can be utilised within organisations to reduce stress and burnout and improve workers' abilities to manage their self-care:

- Conduct a stress audit
- Orientation for new employees to encourage realistic expectations
- Support for professional development
- Support for career development such as management training
- Flexible working conditions
- Encourage input into work strategies
- Have clarity of job roles and responsibility
- Recognition and rewards linked to performance outcomes
- Allow autonomy when possible
- Workplace supports such as mentoring and clinical supervision programs.

REFERENCES AND RESOURCES

- Egan, G. (1994). *The Skilled Helper: A Problem-Management Approach to Helping*. California: Brooks/Cole.
- Figley, C.R (Ed) (1995). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner/Mazel.
- Hawkins, P. & Shohet, R. (1989). *Supervision in the Helping Professions*. Milton Keynes: Open University Press.
- Skinner, N. & Roche, A. (2005). *Stress and Burnout: A prevention handbook for the alcohol and other drugs workforce*. Flinders University, Adelaide: National Centre for Education and Training on Addiction (NCETA).
- Skinner, N., Roche, A.M., O'Connor, J., Pollard, Y. & Todd, C. (Eds.) (2005). *Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field*. Overview Booklet and CD-Rom. Flinders University, Adelaide: National Centre for Education and Training on Addiction (NCETA).

8.5 HELPING CARERS AND FAMILY MEMBERS OF ADULTS WHO HAVE BEGUN TO REMEMBER OR DISCLOSED ABUSE

It is a very traumatic experience for a parent to discover that their adult child was abused (as a child). They may experience a myriad of emotions such as guilt because they failed to protect their child; ambivalence because of their own relationship with the perpetrator; anger and helplessness. A good strategy may be to provide them with resources to understand what their child is going through, provide appropriate referrals to counsellors for themselves and their family; and legal advocacy services.

Note: Part 6 of this guidebook provides details of some organisations that may be of assistance to clients.

RECOMMENDED READING

Public Health Agency Canada. (2009). *When your partner has been sexually abused*. Available: <http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/whenyourpartner.pdf>

Brodie, F. (1992). *When the Other Woman Is His Mother*. Tacoma, Wa.: Winged Eagle Press.

Davis, L. (1991). *Allies in Healing*. New York, New York: Harper Collins.

Engel, B. (1991). *Partners In Recovery: How Mates, Lovers and Other Prosurvivors Can Learn to Support and Cope with Adult Survivors of Childhood Sexual Abuse*. Los Angeles, California: Lowell House.

Gil, E. (1992). *Outgrowing the Pain Together-*. New York, New York: Dell.

Graber, K. (1991). *Ghosts in the Bedroom*. Deerfield Beach, Florida: Health Communications.

Hansen, P. (1991). *Survivors and Partners*. Longmont, Colorado: Heron Hill Publishing.

8.6 DEBRIEF

EXERCISE 31

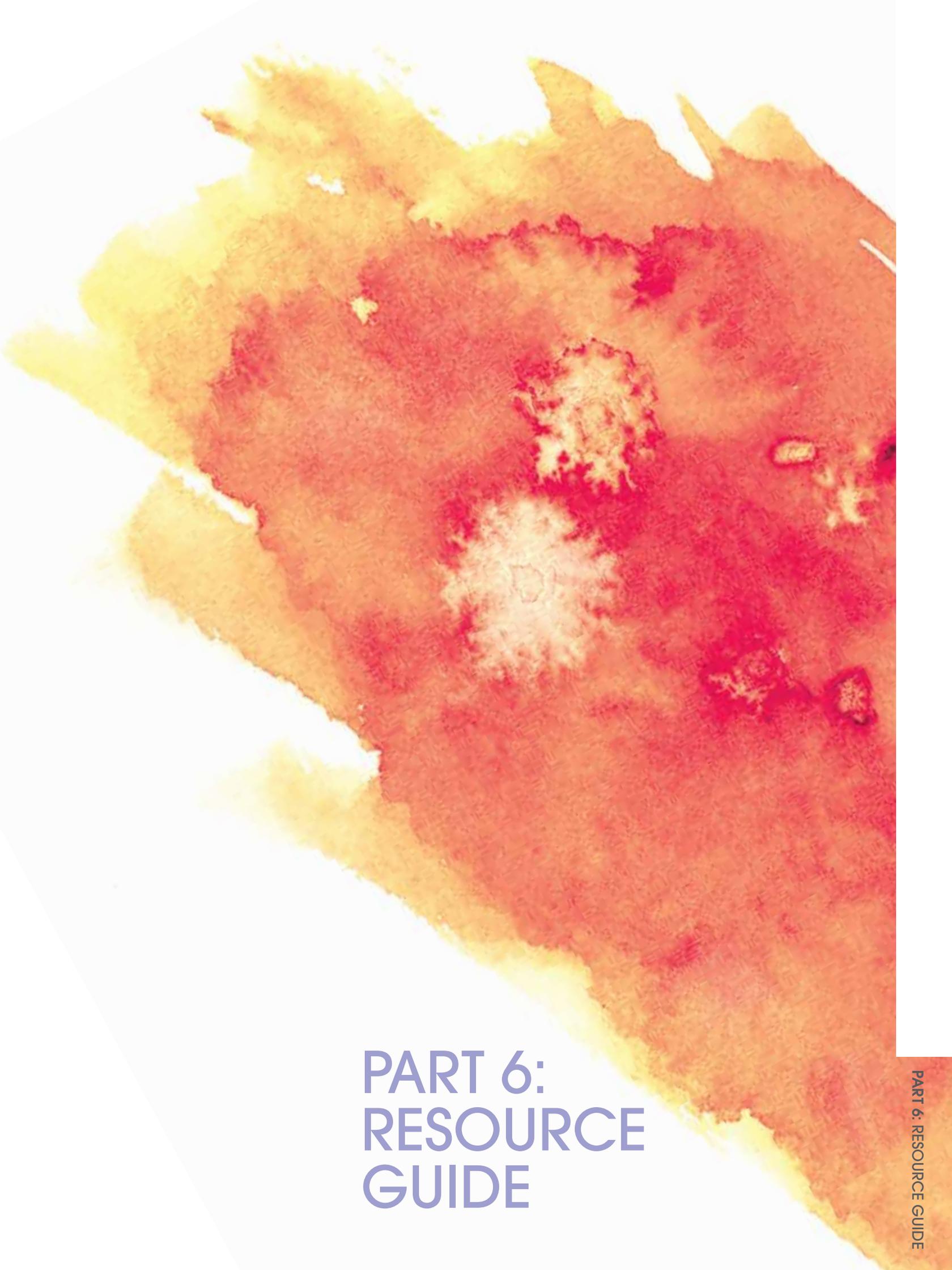
Make a list of some of the personal issues that have come up for you whilst working through this resource Workbook

Debrief with your supervisor regarding any issues of concern or make an appointment with a counsellor if you have any personal concerns about yourself having read this material

The Mental Health Coordinating Council hope that the reader finds the Information Resource Guide and Workbook useful to the work that they undertake now and in the future.

We welcome comments on the contents.

Printed copies of this manual are available for a fee of \$20.

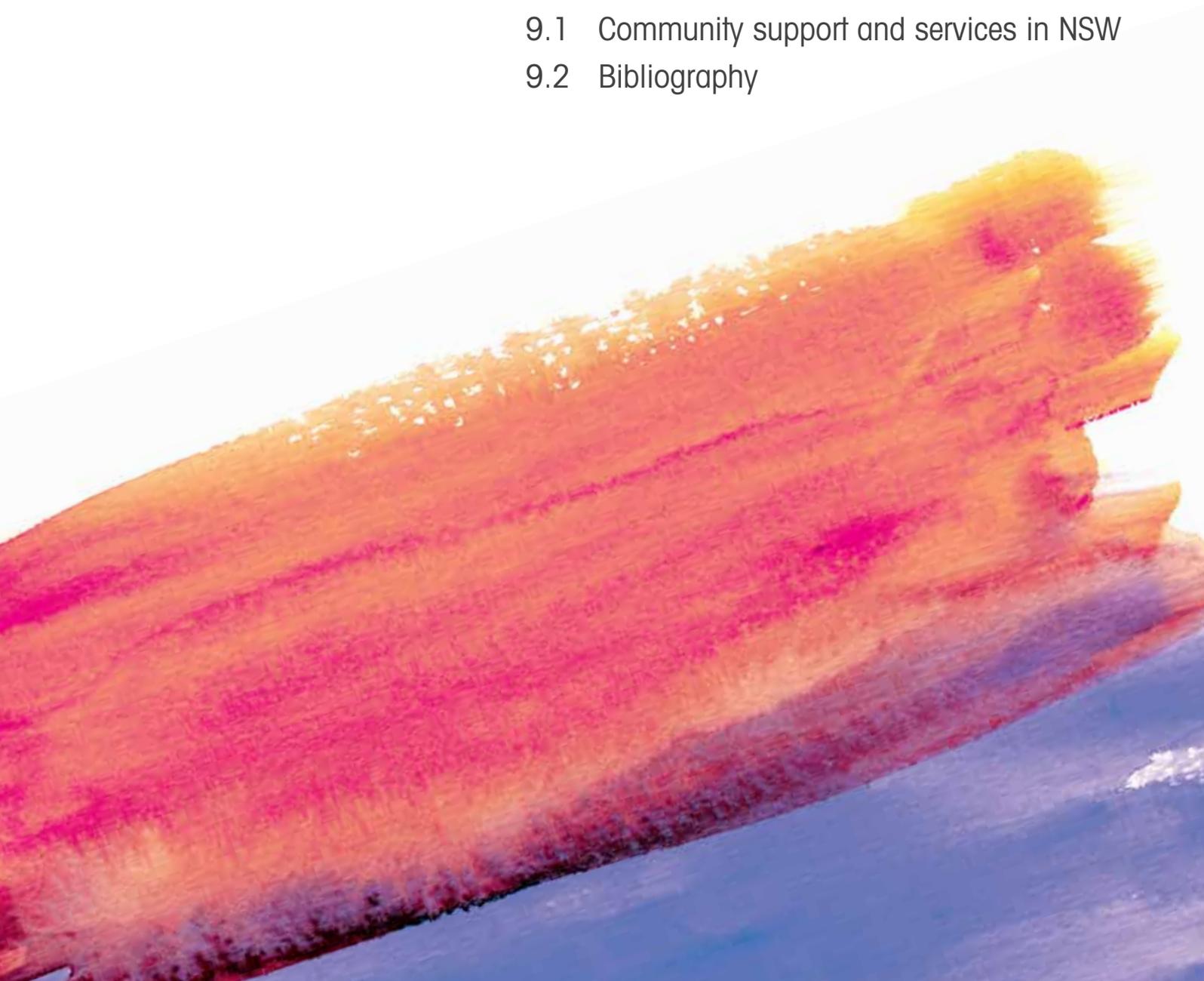


PART 6: RESOURCE GUIDE

CHAPTER 9

9.1 Community support and services in NSW

9.2 Bibliography



9.1 COMMUNITY SUPPORT AND SERVICES IN NSW

Note: Details correct at publication. Please advise MHCC of any amendments as they arise.

ADULT SURVIVORS OF CHILDHOOD ABUSE – SUPPORT SERVICES

Advocates for Survivors of Child Abuse

ASCA is a national organisation which works to improve the lives of adult survivors of child abuse throughout Australia.

Info & support line: 1300 657 380 – (10am to 3pm, Mon to Fri)
Kirribilli Neighbourhood Centre, 16–18 Fitzroy St, NSW Kirribilli 2061
Tel: (02) 8920 3611 **E:** Sydney@asca.org.au
<http://www.asca.org.au>

NSW Rape Crisis

24 hour telephone and online crisis counselling, support and referral service for anyone in NSW who has experienced sexual violence.

Counselling: 1800 424 017
Tel: (02) 9819 7357 **E:** info@nswrapecrisis.com.au
<http://www.nswrapecrisis.com>

Northern Sydney Sexual Assault Service

Royal North Shore Hospital
Building 30, Block 1A, Pacific Highway, St Leonards 2065
Tel: (02) 9926 7580 (8.30–5.00 weekdays)
(02) 9926 7111 (after hours)

Southern Sydney Sexual Assault Service

St George Hospital
36 Belgrave St, Kogarah 2217
Tel: (02) 9350 2494 / (02) 9350 2495 / after hours: (02) 9350 1111

Sydney Women's Counselling

The Sydney Women's Counselling Centre is a service for women, providing: counselling, information, groups and support.

2 Carrington Square, Campsie 2194
Tel (02) 9718 1955 **TTY:** (02) 9718 8807
E: help@womenscounselling.com.au
<http://www.womenscounselling.com.au>

West Street

Counselling services for adult women survivors of childhood abuse.

42 West Street, Wollongong
Tel: (02) 422 6441 **E:** admin@weststreet.com.au

CRISIS LINES / SUICIDE PREVENTION

Child Protection and Family Crisis Services – 1800 066 777

24 hour crisis counselling service in NSW

Child Protection Helpline: 132 111

To report suspected child abuse or neglect – 24/7

Domestic Violence Line 1800 656 463 (TTY 1800 671 442)

If you or someone you know is experiencing domestic violence.

NSW free-call number available – 24/7

Domestic Violence Advocacy Service 1800 810 784

Emergency Services – 000

Emergency service for NSW to connect to ambulance, police, fire services.

<http://www.police.nsw.gov.au>

Lifeline – 13 11 14

Anyone can call Lifeline. They provide a service that offers counselling that respects everyone's right to be heard, understood and cared for. They also provide information about other support services available in communities around Australia.

Crisis Line: 13 11 14 **Admin Tel:** (02) 6215 9400

http://www.lifeline.org.au/find_help/24_hour_counselling_service

NSW Mental Health Services – Crisis numbers

24-hour emergency phone numbers by region

NORTHERN SYDNEY/ CENTRAL COAST	
Northern Sydney:	1300 302 980
Central Coast:	02 4320 3500
SOUTH EASTERN SYDNEY/ ILLAWARRA	
South Eastern Sydney:	1300 300 180
Illawarra:	1300 552 289
SYDNEY SOUTH WEST	1800 636 825
SYDNEY WEST	1800 650 749
GREATER SOUTHERN	
Western (former Greater Murray):	1800 800 944
Eastern (former Southern):	1800 677 114
GREATER WESTERN	
Central and Far West:	1800 011 511
HUNTER/ NEW ENGLAND	
Hunter:	1800 655 085
New England:	1300 669 757
NORTH COAST	1300 369 968

NSW Rape Crisis – 1800 424 017

24 hour telephone and online crisis counselling, support and referral service for anyone in NSW who has experienced sexual violence.

Tel: (02) 9819 7357 **E:** info@nswrapecrisis.com.au
<http://www.nswrapecrisis.com>

Suicide Helpline – 1300 651 251

24 hour counselling service

Website has links with information for those bereaving, and information on suicide prevention.

<http://www.suicidehelpline.org.au>

Suicide Call Back Service

Referral line for people at risk of suicide, people caring for someone who is suicidal or people bereaved by suicide. Service offers six sessions of 50 minute telephone counselling over a period of up to six months.

Referral line: 1300 659 467 (10am to 8:30pm everyday)
<http://www.suicidecallbackservice.org.au>

Salvo Crisis Lines & Suicide Prevention

Compassion and support, guidance and counselling to individuals, couples and families of all ages, and in all walks of life.

Suicide Prevention Crisis Line: (02) 9311 2000 (Sydney local call – 24/7)

Salvation Army 24-hour Care Line: 1300 363 622 (24/7)

<http://www.salvos.org.au>

HELP LINES/COUNSELLING SERVICES

Advocates for Survivors of Child Abuse

ASCA is a national organisation which works to improve the lives of adult survivors of child abuse throughout Australia.

Info & support line: 1300 657 380 – (10am to 3pm, Mon to Fri)

Kirribilli Neighbourhood Centre

16–18 Fitzroy St, NSW Kirribilli 2061

Tel: (02) 8920 3611
<http://www.asca.org.au>

Alcohol & Drug Information Services

Where to go for help if you or someone you know has problems with alcohol.

Helpline: 1800 422 599 (NSW country) (02) 9361 8000 (Sydney). Available 24/7.
<http://www.alcohol.gov.au>

Cannabis Information and Helpline 1800 30 40 50

Chemist Emergency Prescription Referral Service

Tel: (02) 9467 7100. After hours service.

G Line Gambling Hotline – 1800 633 635

Problem gambling information, counselling and referral help line. Available 24/7.

<http://www.olgr.nsw.gov.au>

Lismore Child and Adolescent Sexual Assault Counselling Service

Tel: (02) 6621-9861, 24 hr Crisis line (02) 6621-8000 (After Hours)

Mensline – 1300 78 99 78

Confidential and anonymous counselling, information, and referral for all men (in all relationships). Australia wide service available 24/7.

<http://www.menslineaus.org.au>

NSW Rape Crisis

Provide community-based face-to-face counselling at women's centres across NSW for adult survivors

- Central Coast Community Women's Health Centre, Tel 02 4324 2533
- Central West Women's Health Centre, Tel 02 6331 4133
- Leichhardt Women's Community Health Centre, Tel 02 9560 3011
- Lismore and District Women's Health Centre, Tel 02 6621 9800
- Liverpool Women's Health Centre, Tel 02 9601 3555
- Penrith Women's Health Centre, Tel 02 4721 8749
- Women's Centre Albury-Wodonga, Tel 02 6041 1977

Parent Line – 1300 30 1300

Confidential telephone counselling service aimed at providing professional counselling and support for parents and all who have the care of children.

<http://www.parentline.com.au>

Richmond Sexual Assault Service

Crisis line for children & adolescents

Tel: (02) 6620 2970. 24 hr Crisis line (02) 6621-8000 (After Hours)

Rural Mental Health Support Line NSW – 1800 201 123

The Rural Support Line, available 24/7, can provide on-the-spot help in an immediate crisis or help with referral to local specialist services.

SANE Helpline: 1800 18 SANE (7263)

Provides information about symptoms, treatments, medications, where to go for support and help for carers. 9am to 5pm, Monday to Friday.

E: helpline@sane.org

<http://www.sane.org>

Tresilian Family Care Centres (Sydney Metro)

Parent Helpline: (02) 9787 5255 / 1800 637 357

MENTAL HEALTH ORGANISATIONS

Australasian Society for Traumatic Stress Studies (ASTSS)

ASTSS provides a forum for extending the understanding, prevention and treatment of major stress and trauma within the Australasian region.

E: gcoman@nags.org.au

<http://www.astss.org.au>

Australia and New Zealand Mental Health Association Inc

The role of the Association is to advance the field of mental health in the Region by the application of knowledge about mental health. From mental health education, training, research to mental health advocacy.

E: admin@anzmh.asn.au

<http://www.anzmf.asn.au>

beyondblue: the national depression initiative

beyondblue is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related substance misuse disorders in Australia.

<http://www.beyondblue.org.au>

Black Dog Institute

An educational, research, clinical and community-oriented facility offering specialist expertise in mood disorders including depression and bipolar disorder.

Prince of Wales Hospital,

Hospital Road, Randwick NSW 2031

General Information: (02) 9382 4530

Community/Consumer Enquiries: (02) 9382 4523

Clinics: (02) 9382 2991

E: blackdog@blackdog.org.au

<http://www.blackdoginstitute.org.au>

Mental Health Council of Australia (MHCA)

Peak national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians.

Tel: (02) 6285 3100 E: admin@mhca.org.au

<http://www.mhca.org.au>

Mental Health Association NSW Inc

MHA provides information, support and education to people who are affected by the symptoms of mental illness, and undertakes advocacy for systemic change.

Tel: Information Service: 1300 794 991 E: mha@mentalhealth.asn.au

<http://www.mentalhealth.asn.au>

Mental Health Coordinating Council (MHCC)

MHCC is the state peak body for non-government organisations (NGOs) working for mental health throughout NSW, representing the views and interests of over 200 member NGOs specialising in the provision of services and support for people with a disability as a consequence of mental illness. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services to the community. Facilitating effective linkages between government, non-government and private sectors, MHCC participates extensively in public policy development. The organisation consults broadly across all sectors in order to respond to legislative reform and sits on National, State (NSW) and State Government Department (NSW) committees and boards in order to affect systemic change. MHCC manages and conducts research projects and develops collaborative programs on behalf of the sector, and is a registered training organisation, delivering mental health training to the workforce.

Tel: (02) 9555 8388 E: info@mhcc.org.au

<http://www.mhcc.org.au>

Mental Health Foundation Australia (MHFA)

Raises funds to promote mental health and wellbeing, public involvement in mental health, removal of the stigma linked with mental illness, research on mental health issues, effective prevention programmes, and mental health education.

Tel: (03) 9427 0407 E: admin@mhfa.org.au

<http://www.mhfa.org.au>

Mental Illness Fellowship of Australia (MIFA)

National body with state and territory member organisations that support and represent people with a severe mental illness and their carers.

Tel: (08) 8221 5072

<http://www.mifa.org.au>

SANE

A national charity that conducts innovative programs and campaigns to improve the lives of people living with mental illness, their family and friends. It also operates a busy Helpline and website, which have thousands of contacts each year from around Australia.

Tel: (03) 9682 5933 E: info@sane.org / helpline@sane.org

SANE Helpline: 1800 18 SANE (7263)

<http://www.sane.org>

The Schizophrenia Fellowship of NSW

An organisation committed to improving the circumstances and welfare of people affected by schizophrenia. They provide information, understanding, advocacy and support services. A state-wide organisation with many outlets both in metropolitan Sydney and in rural NSW.

Tel: (02) 9879 2600 E: admin@sfnsw.org.au

<http://www.sfnsw.org.au>

Suicide Prevention Australia (SPA)

National umbrella body active in suicide prevention. Suicide Prevention Australia is a non-profit, non-government organisation working as a public health advocate in suicide prevention.

Tel: (02) 9568 3111 E: info@suicidepreventionaust.org
<http://suicidepreventionaust.org>

CONSUMER ORGANISATIONS

The Consumer Activity Network (Mental Health) Inc.

CAN is an independent, not-for-profit consumer organisation established with an overall purpose to enable, support and connect mental health consumers in their recovery, and advocate for their voices to be included across all levels of the mental health service system.

Tel: (02) 8206 1841 E: desley@canmentalhealth.org.au
<http://www.canmentalhealth.org.au>

GROW

GROW is a community of persons working towards mental health through mutual help and a 12 step program of recovery. Small groups of people come together on a weekly basis to help each other deal with the challenges of life.

Tel: 1800 558 268 – Australia Wide Tel: (02) 9633 1800 – NSW
<http://www.grow.net.au/>

New South Wales Consumer Advisory Group – Mental Health Inc (NSW CAG)

Provides an ongoing mechanism for mental health consumer and carer participation into policy and service development, implementation and evaluation.

Tel: (02) 9332 0200 E: info@nswcag.org.au
<http://www.nswcag.org.au>

CARERS, FAMILY & FRIENDS

ARAFEMI Online Support

The ARAFEMI message board and chat provide an opportunity for carers of people with a mental illness to gain mutual support and encouragement in a safe environment.

Carer helpline: 1300 550 265 9am–5pm, Monday to Friday
<http://www.arafemi.org.au/family-support/online-support.html>

ARAFEMI NSW

ARAFEMI provides support and advocacy for families and friends of people with mental illness or disorder. ARAFEMI reaches out with friendship and understanding to all whose lives are touched by mental illness. Offices in: Illawarra, North Sydney, Hunter, North Ryde, Sydney.

Information and Support Line: 9332 0700
Admin Head Office: Tel: (02) 9332 0777
<http://www.arafmi.org>

Carers NSW

Carers NSW is the peak organisation association for relatives and friends caring for people with a disability, mental illness, drug and alcohol dependencies, chronic condition, terminal illness or who are frail.

Tel: (02) 9280 4744 E: contact@carersnsw.asn.au
<http://www.carersnsw.asn.au>

Siblings Australia

Siblings Australia is a unique national organisation committed to providing support for brothers and sisters of people with special needs; including disability, chronic illness and mental health issues.

Tel: (08) 83571214 E: info@siblingsaustralia.org.au
<http://www.siblingsaustralia.org.au>

DEPRESSION / ANXIETY DISORDERS

Anxiety Network Australia

Comprehensive Australia-wide service providing information, education and support to people who live with all the major anxiety conditions. Provides relevant information on anxiety conditions, causes, treatments, and more.

E: contact@anxietyhelp.com.au
<http://www.anxietynetwork.com.au>

Aussie Helpers

Aussie helpers help fight poverty and lift the spirits of those severely affected by drought in the outback. Aussiehelpers have 25 volunteers and mainly work via 'bush-telegraph' to find farming families who are in desperate need of assistance.

Tel: 1300 665 232 (24/7 Australia wide) E: admin@aussiehelpers.org.au
<http://www.aussiehelpers.org.au>

Back from the Brink

First hand knowledge and tips on overcoming depression. Back from the Brink is a website of hope, dedicated to helping people manage their depression.

<http://www.iambackfromthebrink.com/index.asp>

beyondblue: the national depression initiative

beyondblue is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related substance misuse disorders in Australia.

<http://www.beyondblue.org.au>

Clinical Unit for Anxiety and Depression (CRUfAD)

A research unit focused on online education and treatment for health and wellbeing. It offers self-help information, clinician support and research updates.

299 Forbes Street, Darlinghurst, NSW 2010

Tel: (02) 8382 1730
<http://www.crufad.com>

depressionservices.org.au

A service portal offering a diverse range of interactive human services, including free counselling and peer support, utilising online technologies for Australians living with depression to help improve their mental health and wellbeing.

<http://www.depressionservices.org.au>

Men's Sheds

Men's Sheds connect men with their communities and play a practical role in assisting with issues such as health, isolation and depression whilst providing a place to meet and the possibility of putting something back into their communities.

Tel: (02) 9890 8351

<http://www.mensheds.com.au>

MoodGYM Training Program

Cognitive behavioural therapy skills for preventing and coping with depression.

<http://moodgym.anu.edu.au>

Social Phobia Education Program (SPEP)

Education program designed to teach people with social phobia about their symptoms, and to show them ways of managing their symptoms, all done over the Internet.

<http://www.shyness.tv>

Virtual Clinic

An Internet-based clinic that aims to develop and provide free education and treatment programs for people with anxiety and depressive disorders who cannot readily access face-to-face treatment.

<http://www.virtualclinic.org.au>

EATING DISORDERS

Australian and New Zealand Academy for Eating Disorders (ANZAED)

Peak body representing and supporting the activities of all professionals working in the field of eating disorders and related issues.

E: info@anzaed.org.au

<http://www.anzaed.org.au>

Bulimia Help

Bulimia Help is a self-help recovery website devoted to motivate and encourage everyone with bulimia to take action and make their recovery possible.

<http://www.bulimiahelp.org>

The Butterfly Foundation

Support provided for Australians experiencing eating disorders and negative body image issues and their carers through: 'Direct Relief' for treatment and support, telephone & online support, health promotion programs, effective treatment options, advocacy and awareness.

Tel: (02) 9412 4499 E: info@thebutterflyfoundation.org.au
<http://www.thebutterflyfoundation.org.au>

NSW Centre for Eating and Dieting Disorders (NSW CEDD)

Eating and dieting disorders information, resources and support centre based in Sydney. A collaboration between the University of Sydney and Sydney South West Area Health Service.

Tel: (02) 9515 5843 E: info@cedd.org.au
<http://www.cedd.org.au>

GRIEF & LOSS

Australian Centre for Grief & Bereavement Inc

Provider of grief and bereavement education in Australia.

Freecall: (Australia wide) 1800 642 066 Tel: (03) 9265 2100
 E: info@grief.org.au
<http://www.grief.org.au>

Bereavement Care Centre

The Centre's goals are to provide comprehensive and accessible counselling and support services for the terminally ill and their families, and for those recently bereaved.

Tel: 1300 654 556 or (02) 9804 6909
 E: info@bereavementcare.com.au
http://www.bereavementcare.com.au/about_us.htm

Australian Child & Adolescent Trauma, Loss & Grief Network (ACATLGN)

For everyone involved in the care of children/youth and interested in the potential impact of trauma, loss and grief experiences

Tel: 1800 620 032 E: admiss.eng@anu.edu.au
<http://www.earlytraumagrieff.anu.edu.au>

National Association for Loss And Grief (NSW) NALAG

NALAG Incorporated was founded in 1977 after the Granville train disaster. Its aim is to encourage and promote professional and community education in loss and grief, through the establishment of support groups throughout Australia.

Tel: (02) 68829222 E: info@nalag.org.au
<http://www.nalag.org.au/history.html>

Salvo Hope for Life

Suicide bereavement support for people bereaved by suicide.

Hopeline: 1300 467 354

<http://www.salvos.org.au>

Traumatic Stress Clinic

Provides evidence-based treatments and undertakes research for post-traumatic stress disorder and complicated grief. The clinic operates out of Westmead Hospital and the University of NSW.

Acacia House, Westmead Hospital, WESTMEAD NSW 2154

Tel: (02) 9845 7979 or (02) 9845 6904 **E:** traumaticstressclinic@brain-dynamics.net

<http://www.traumaticstressclinic.com>

KIDS / YOUTH

Bursting the Bubble

Resource for young people dealing with abuse, with information on: how it affects you; safety strategies; and true stories from young people.

<http://www.burstingthebubble.com>

Child Wise

Works to prevent and reduce the sexual abuse and exploitation of children in Australia and overseas. They combine direct support, counselling, education, advocacy, program implementation, participatory training, capacity-building and research to provide a comprehensive, strong and specialised service.

Tel: (03) 9645 8911 **Freecall:** 1800 99 10 99 within Australia

E: office@childwise.net

<http://childwise.net>

Children Of Parents with a Mental Illness

Provides advocacy, support, information, help and respite to young carers.

Tel: (08) 8367 0888 **E:** copmi@aicafmha.net.au

<http://www.copmi.net.au>

Community Services (formerly DoCS)

Provides child protection services, parenting support and early intervention, foster care, adoption services and help for communities affected by disaster.

Child Protection Helpline: 132 111

To report suspected child abuse or neglect (24 /7)

<http://www.community.nsw.gov.au>

Family separation: a guide for teens

The CSA and beyondblue have partnered to develop this online resource for teenagers sharing stories, tips and strategies for dealing with separation.

<http://www.youth.csa.gov.au>

Gambling Hangover

Gambling campaign aimed at young men 18–24, offering a range of new help and support options.

Gambling Helpline: 1800 858 858
<http://www.gamblinghangover.nsw.gov.au>

headspace – National Youth Mental Health Foundation

Youth mental health information and resources with centres across Australia including:

headspace Camperdown – Sydney
 Level 2, 97 Church St, Camperdown, 2050
 Opening Hours: 9am – 5pm Monday to Friday
Tel: (02) 9114 4100 **E:** info@headspace.org.au
<http://www.headspace.org.au>

highsnlows

Information for young people about how cannabis use can affect their mental health and where they can find help.

Tel: (03) 9278 8100
<http://www.highsnlows.com.au>

Inspire Foundation

Inspire combines technology with the direct involvement of young people to deliver innovative and practical online programs that prevent youth suicide and improve young people's mental health and wellbeing.

Tel: (02) 8585 9300
<http://www.inspire.org.au>

Itsallright

For teens in families affected by mental illness. Offers factsheets and podcasts and provides an online information and referral service on mental illness including schizophrenia, depression and anxiety disorders.

<http://www.itsallright.org>

Kids Helpline

Kids Helpline is a free, 24 hour counselling service for young people aged 5–25 years. Counselling is offered by phone, email and over the web.

Kids Helpline: 1800 55 1800 **Tel:** 07 3369 1588 **E:** admin@kidshelp.com.au
<http://www.kidshelp.com.au>

KidsMatter

Primary school mental health promotion, prevention and early intervention initiative.

E: enquiries@kidsmatter.edu.au
<http://www.apapdc.edu.au/kidsmatter>

Legal Aid

Legal advice for young people who have committed, or are suspected of committing, a criminal offence. (9am to midnight weekdays, 24 hours Fri to Sun)

Tel: (02) 9219 5000 **TTY:** (02) 9219 5126

Youth Hotline: 1800 10 18 10

<http://www.legalaid.nsw.gov.au>

MindMatters

Resource and professional development program to support Australian secondary schools in promoting and protecting the social and emotional wellbeing of members of school communities.

E: vanessa.houltby@pa.edu.au

<http://www.mindmatters.edu.au/default.asp>

Reach Out

Aimed at kids and teenagers. A little bit like Kids Help Line where it enables anyone of any age to use the site and gain information, or talk to someone. This will take you straight to info on depression.

Helpline & emergency info: 1800 55 1800 (free call from landline)

<http://au.reachout.com>

Salvo Youth Line

For young people and parents who want to discuss problems, personal issues, relationship problems or dilemmas at school.

Salvo Youth Line: (02) 8736 3293 (Sydney local call) 24/7

Tel: 02 9264 1711 (admin)

<http://www.salvos.org.au>

WEEO WISER

Equips young women with knowledge, skills and attitudes to reject violent, abusive relationships and to expect healthy, safe, equal relationships through a peer education project and website information.

Tel: (02) 9601 3555 **E:** Eliza.Kilpatrick@sswahs.nsw.gov.au

<http://www.weeowiser.org.au>

Youthbeyondblue.com

beyondblue's mental health website for young people includes information on depression and anxiety, how to get help, resources and events.

<http://www.youthbeyondblue.com>

Young Carers – NSW

Provides services for young people, 25 years or under, who help care for a family member or friend who has an illness, disability, drug or alcohol or mental health issue.

Tel: (02) 9280 4744 **E:** yc@carersnsw.asn.au

<http://www.youngcarersnsw.asn.au>

MULTICULTURAL SERVICES

Australian National Committee on Refugee Women (ANCORW)

Lobbying, advocacy and research group which works with and for refugee women and their families in order to bring about change in the refugee system and to enhance their ability to rebuild their lives.

Tel: (02) 9385 1961 E: ancorw@ancorw.org
<http://www.ancorw.org>

Immigrant Women's Speakout Association

Peak advocacy, information, referral and research body representing the ideas and issues of immigrant and refugee women in NSW. Also provides direct services in the areas of bilingual counselling, domestic violence, employment, education and training.

Tel: (02) 9635-8022 E: women@speakout.org.au
<http://www.speakout.org.au>

MIDonline: Multicultural Information on Depression

Provides multilingual and culturally relevant information on depression for CALD adult populations in Australia.

E: litza.kiropoulos@med.monash.edu.au
<http://www.midonline.com.au>

Multicultural Mental Health Australia (MMHA)

Multicultural Mental Health Australia is the national program in multicultural mental health and suicide prevention, funded under the National Mental Health Strategy and National Suicide Prevention Strategy by the Department of Health and Ageing.

Tel: (02) 9840 3333 E: admin@mmha.org.au
<http://www.mmha.org.au>

The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)

Helps refugees recover from their experiences and build a new life in Australia. Services include counselling, group therapy, group activities and outings, camps for children and young people, English classes and physiotherapy.

Tel: (02) 9794 1900 E: startts@sswahs.nsw.gov.au
<http://www.startts.org.au>

Transcultural Mental Health Centre

Aims to improve the mental health and wellbeing of people of non-English speaking background through a community capacity building approach.

Tel: (02) 9840 3800 E: dhi@swahs.health.nsw.gov.au
<http://www.dhi.gov.au/tmhc/tmhc/default.aspx>

Translating and Interpreting Service (TIS) National

The Department of Immigration and Citizenship (DIAC) provides the interpreting service for people who do not speak English and for the English speakers who need to communicate with them.

Tel: 131 450 – to use an interpreter over the telephone. Available 24 hours
 Or visit website to book an interpreter <http://www.immi.gov.au/tis>

COMMUNITY-BASED SERVICES

Neami

Neami is a psychosocial health and rehabilitation support provider, who works with and on behalf of people with a mental illness. Neami works to identify service gaps in the community, develop new services and to achieve community acceptance, protection and expression of the rights of people with psychiatric disabilities in the community.

Tel: (02) 9798 2111 **E:** centralsydney@neami.org.au
<http://www.neami.org.au>

Psychiatric Rehabilitation Association

Provides community-based support services to people with psychosocial disadvantage or psychiatric disability, as well as non-clinical rehabilitation aimed at reducing people's dependence and increasing self-esteem and satisfaction.

Level 11, 1 Lawson Square, Redfern, NSW, 2016
Tel: (02) 9690 8900 **E:** info@pra.org.au
<http://www.pra.org.au>

Richmond Fellowship of NSW

RFNSW's purpose is to enhance the lives of people affected by mental illness. This is achieved through promotion of mental health and recovery and by providing community-based rehabilitation within an accommodation support framework.

Tel: (02) 9701 3600
<http://www.rfnsw.org.au>

MAKING A COMPLAINT

NSW Health Care Complaints Commission (HCCC)

The HCCC investigates and prosecutes complaints against health care providers in NSW. Complaints can be made about individual providers, doctors, nurses, naturopaths, counsellors, and dentists, or about services at places such as public/private hospitals, medical centres and nursing homes.

Hotline: 1800 043 159 **Direct:** (02) 9219 7444 **E:** hccc@hccc.nsw.gov.au
<http://www.hccc.nsw.gov.au>

Ombudsman

We consider and investigate complaints from people who believe they have been treated unfairly or unreasonably by an Australian Government department or agency.

Level 7, North Wing, Sydney Central, 477 Pitt Street
Sydney NSW 2000
Tel: 1300 362 072 **E:** ombudsman@ombudsman.gov.au
<http://www.ombudsman.gov.au>

GETTING HELP – COUNSELLING & THERAPY

Adults Surviving Child Abuse ASCA

ASCA is a national organisation which works to improve the lives of adult survivors of child abuse throughout Australia. ASCA runs psycho educational workshops for survivors nationally.

Kirribilli Neighbourhood Centre, 16–18 Fitzroy St, Kirribilli 2061

Tel: (02) 8920 3611 E: admin@asca.org.au

<http://www.asca.org.au>

Australian Association of Relationship Counsellors (AARC) Inc

Professional association for relationship counsellors. Website provides a 'find a counsellor' directory.

Free call: 1800 806 054 E: contact@aarc.org.au

<http://www.aarc.org.au>

Australian Counselling Association (ACA)

National professional peak association for counsellors. Website provides a 'find a counsellor' directory.

Tel: (07) 3356 4255 / 1300 784 333 E: aca@theaca.net.au

<http://www.theaca.net.au>

Australian Psychological Society

APS is the largest professional association for psychologists in Australia. Website provides a 'find a psychologist' directory.

Tel: (03) 8662 3300 Toll free: 1800 333 497 E: contactus@psychology.org.au

<http://www.psychology.org.au>

Australian and New Zealand Association of Psychotherapists

Listing of psychotherapists available on website.

<http://www.anzapweb.com/html>

Find a Therapist Anywhere in Australia

Find a practitioner, treatment centre and get the latest news on health issues.

<http://www.findatherapist.com.au/index.aspx>

The Counsellors and Psychotherapists Association of NSW

CAPA is the peak New South Wales Counselling and Psychotherapy Association. Website provides a 'find a therapist' directory.

<http://www.capa.asn.au>

Choosing Therapy

National counsellor and psychotherapist directory.

<http://www.choosingtherapy.com>

Goodtherapy

Dedicated to making good therapy more accessible. Website provides a 'find a therapist' directory.

http://www.goodtherapy.com.au/find_a_therapist.php

Psychotherapy and Counselling Federation of Australia

National peak body for professional practitioners of counselling and psychotherapy in the Australian community. Website provides a 'find a therapist' directory.

Tel: (03) 9486 3077 E: admin@pacfa.org.au

<http://www.pacfa.org.au>

Relationships Australia

Providing relationship support services to enhance human and family relationships. These services, including counselling and mediation are offered in many locations across Australia.

National line: 1300 364 277

Tel: (02) 9425 4999 (admin)

<http://www.relationships.com.au>

SIDS & KIDS

Works to eliminate sudden and unexpected infant deaths, and supports bereaved families through education, research, evidenced-based intervention and advocacy. 24 hour bereavement support.

Bereavement support line: 1800 651 186

COUNSELLING – ONLINE

DailyStrength

Online community support groups for people with health or mental health problems. Discussions, recommendations, advice and news.

<http://www.dailystrength.org>

E-couch

Provides evidence-based information about emotional problems (including depression and anxiety disorders) and teaches strategies that help prevent problems and understand oneself better.

http://www.ecouch.anu.edu.au/new_users/welcome03

DISABILITY

National Disability Services

NDS is the national industry association for disability services, representing over 640 not-for-profit organisations. Collectively, all members operate several thousand services for Australians with all types of disability.

Tel: (02) 9256 3111 E: ndsnsw@nds.org.au

<http://www.nds.org.au/nsw/index.html>

People with Disability (PWD)

PWD is a national peak disability rights and advocacy organisation for Australia.

Tel: (02) 9370 3100 Toll Free: 1800 422 015 E: pwd@pwd.org.au
<http://www.pwd.org.au>

Women with Disabilities Australia (WWDA)

Peak organisation for women with all types of disabilities in Australia, providing support and advocacy, both individually and collectively.

PO Box 605, Rosny Park, Tasmania, 7018
 Tel: (03) 62448288 E: wwda@wwda.org.au
<http://www.wwda.org.au>

EDUCATION/TRAINING

Education Centre Against Violence (ECAV) NSW Health

Provides state-wide specialised training, consultancy and resource development for NSW Health and interagency workers who provide services to children and adults who have experienced sexual assault, domestic or Aboriginal family violence and/or physical and emotional abuse and neglect.

Tel: (02) 9840 3737 E: ecav@wsahs.nsw.gov.au
<http://www.ecav.health.nsw.gov.au>

Hunter Institute of Mental Health

At the Hunter New England Area Health Service. Provides a range of education and training programs as well undertaking health promotion projects in the Hunter region and across Australia.

Tel: (02) 4924 6900 E: himh@hnehealth.nsw.gov.au
<http://www.himh.org.au>

Mental Health Coordinating Council – Learning & Development Unit

MHCC works to improve mental health services by promoting and developing the skills, knowledge and qualifications of the community-based workforce particularly in relation to mental health work. As a Registered Training Organisation (RTO), we deliver nationally recognised qualifications.

Tel: (02) 9555 8388 ext 106 E: training@mhcc.org.au
<http://www.mhcc.org.au/learning-and-training>

New South Wales Institute of Psychiatry (NSWIOP)

Major provider of continuing professional education in mental health.

Tel: (02) 9840 3833 E: institute@nswiop.nsw.edu.au
<http://www.nswiop.nsw.edu.au>

Response Ability

Mental health resources for tertiary education.

Tel: (02) 4923 6780 E: mindframe@hnehealth.nsw.gov.au
<http://www.responseability.org/site/index.cfm>

GENERAL HEALTH

Ageing Well

From Jean Hailes Foundation for Women's Health. Information on emotional wellbeing, as well as good mental and physical function.

<http://www.ageingwell.org.au>

Alcoholics Anonymous (AA)

AA is an organisation that assists alcoholics all over the world to achieve long-term sobriety. It advocates a free, non-professional, 12-step recovery program for its members.

<http://www.aa.org.au>

Family Planning NSW

Provides reproductive and sexual health services in New South Wales

State Office: 328-336 Liverpool Rd, Ashfield NSW 2131

Tel: (02) 8752 4300

Healthline: 1300 658 886

<http://www.fpnsw.org.au>

GENERAL HEALTH – WOMEN

Abortion Help

This site was developed by Marie Stopes International to answer all of your questions on abortion.

<http://www.abortionhelp.com.au>

Networking Women

Information source linking women's organisations and community groups throughout Australia.

<http://www.getnetworking.com.au>

The Office for Women

Australian Government directory of online resources for women.

<http://www.fahcsia.gov.au/sa/women/overview/Pages/default.aspx>

Post & Ante Natal Depression Support & Information Inc (PANDSI)

Information and support to families affected by post and antenatal depression. Their aim is to help reduce the negative outcomes of perinatal mental health conditions and build resilience in mothers.

Tel: (02) 6232 6664 **E:** info@pandsi.org

<http://www.pandsi.org>

Women's Health NSW

An association of statewide women's health centres and specialist women's centres which aim to improve the health of women. The centres aim to blend medical and clinical services and a range of counselling, health promotion, education, self-help and consumer advocacy services.

PO Box 341, Leichhardt NSW

Tel: (02) 9560 0866 **E:** info@whnsw.asn.au

<http://www.whnsw.asn.au>

HOSPITALS/CLINICS/SPECIAL UNITS

Health Services Directory

A directory of NSW public health services including: public hospitals, community, family and children's health centres, ambulance stations, and an extensive range of other services including mental health, dental, allied health, public health, Aboriginal health and multicultural health services.

<http://www.health.nsw.gov.au/services>

NSW Health – Mental Health Services Directory

Listings of NSW Mental Health Services, contact numbers and details.

http://www.sesiahs.health.nsw.gov.au/Mental_Health_Services

NSW Public Hospitals

<http://www.health.nsw.gov.au/hospitals/index.asp>

NSW Health Services Directory

A comprehensive service directory (including search function) created by NSW Health.

<http://www2.health.nsw.gov.au/services>

Private Hospitals – Australian Private Hospitals Association

<http://www.apha.org.au>

Private Clinics and Psychiatric Wards

<http://www.depressionservices.org.au/my-resources/finding-a-clinic-or-psychiatric-ward.html>

HOMELESSNESS/ SUPPORTED ACCOMODATION

Aftercare

Provides 24 hour supported accommodation for young isolated people with mental illness, and former boarding house residents with complex needs.

Tel: (02) 8572 7700

<http://www.aftercare.com.au>

B Miles Womens Housing Scheme

Women's Housing Scheme providing medium-term, supported accommodation for women without dependent children who have a mental illness.

345 Gardeners Rd, Rosebery NSW 2018

Office Hours: 9am–5pm, Mon–Fri.

Tel: (02) 9317 0400 **E:** zed@bmiles.org.au

<http://www.bmiles.org.au>

Homelessness Australia

National peak body working to prevent and respond to homelessness in Australia.

7/114 Maitland St, Hackett. ACT 2602

Tel: 02 6247 7744 **E:** info@homelessnessaustralia.org.au

<http://www.homelessnessaustralia.org.au/site/index.php>

Neami

Neami is a national psychosocial health and rehabilitation support provider, who works with and on behalf of people with a mental illness providing safe, secure and affordable housing coupled with community support.

Tel: (02) 9798 2111 E: centralsydney@neami.org.au
<http://www.neami.org.au>

New Horizons Enterprises Ltd

Provides services in supported accommodation, supported employment for people with disabilities and aged care.

Tel: (02) 9490 0000 E: admin@newhorizons.net.au
<http://www.newhorizons.net.au>

NSW Women's Refuge Resource Centre

A network of women's refuges situated across NSW providing support and accommodation for women and children escaping domestic violence.

Tel: (02) 9698 9777 E: wrrc@wrrc.org.au
<http://www.wrrc.org.au>

Psychiatric Rehabilitation Association

Offers accommodation services in a mix of different support levels.

Tel: (02) 9690 8900 E: info@pra.org.au
<http://www.pra.org.au>

Rebeccas Community

A community group whose staff and volunteers work with people who experience homelessness in Sydney.

Tel: 02 9871 5055 / 0419 433 584 E: dominic.mapstone@gmail.com
<http://www.homeless.org.au>

Richmond Fellowship of NSW

Provides accommodation and outreach support to people with psychiatric disability.

Tel: 02 9701 3600
<http://www.rfnsw.org.au>

INFORMATION/ RESOURCES – ONLINE

ABC Health and Wellbeing

Australian Broadcasting Corporation's online health gateway featuring articles, fact file, quiz, consumer guides, treatments, therapies, links and much more information about health and wellbeing.

<http://www.abc.net.au/health/library/stories/2007/06/05/1944066.htm>

At Ease

Mental health resources targeting veterans, their partners, carers, sons and daughters, and current serving Australian Defence Force (ADF) members.

Info line: 1800 011 046 E: At-Ease@dva.gov.au
<http://at-ease.dva.gov.au/www/html/7-home-page.asp>

Australian Centre for the Study of Sexual Assault (ACSSA)

ACSSA aims to improve access to information and helps to support and develop strategies to reduce the incidence of sexual assault.

Tel: (03) 9214 7888

<http://www.aifs.gov.au/acssa>

Australian Domestic and Family Violence Clearinghouse

Provision of high quality information about domestic and family violence issues and practice. Specifically, the Clearinghouse publishes newsletters and papers on key issues, policy, legislation, training and new initiatives.

Tel: (02) 9385 2990 Freecall: 1800 75 33 82 (only from fixed phones in Australia)

E: clearinghouse@unsw.edu.au

<http://www.austdvclearinghouse.unsw.edu.au>

Australian Drug Information Network (ADIN)

This website has an extensive listing of all available information on medications, drugs, intervention and drug issues. It also caters for students, professionals, and the general public wanting to find information.

http://www.adin.com.au/content.asp?Document_ID=1

Australia and New Zealand Mental Health Association

The aim of the Association is to provide knowledge about mental health to the public, educate and train professionals in mental health practices, advance knowledge/research in the field, and advocate for improved mental health and mental health services.

<http://anzmh.asn.au>

Blue Pages

This website provides information about depression and resources.

<http://bluepages.anu.edu.au>

Centre for Road Trauma Recovery

Provision of an Information website & resources to help road trauma survivors & their families with the recovery process.

<http://www.roadtraumarecovery.org.au/index.html>

Changing Minds

Developed by the Mental Health Association NSW, this website is intended to promote positive mental health and wellbeing in a fun, interactive and informative way, targeted to the Australian community at large.

<http://www.changingminds.org.au/home.php>

communityNet

A news, information and resources website for the community sector in Western Sydney and information technology services across the NSW sector.

Tel: (02) 47 211 866

<http://www.cnet.ngo.net.au/>

HealthInsite

HealthInsite is the Australian Government's Internet gateway to reliable health information online. It provides access to over 15,000 information items on the websites of its approved information partners.

<http://www.healthinsite.gov.au>

Hope for Life Suicide Prevention & Bereavement Support – The Salvation Army

Information on how to support someone affected by suicide and details of agencies people can ring for support; as well as an online training program for people that work with people bereaved through suicide.

Hopeline: 1300 467 354

<http://salvos.org.au/suicideprevention>

JustAskUs

Aimed at university students who are seeking information or help in relation to alcohol, drugs, mental health and wellbeing. Provides information on a variety of health topics and links to support services.

<http://www.justaskus.org.au>

Lifeline Service Finder

A directory of free or low-cost health and community services available in Australia, including accommodation, domestic violence, family and children's services, financial assistance and mental health services.

http://www.lifeline.org.au/find_help/service_finder

Mental Health & Well Being

Information on Government health programs, funding opportunities, publications, and policies.

<http://www.health.gov.au/internet/mentalhealth/Publishing.nsf/Content/Home-1>

Mindframe Media

Resources produced for the mental health sector under the Mindframe National Media Initiative. Includes resource book and quick reference cards and information on talking to the media about suicide and mental illness.

<http://www.mindframe-media.info>

National Cannabis Prevention and Information Centre (NCPIC)

The NCPIC was established to reduce the use of cannabis in Australia by preventing uptake and providing the community with evidence-based information and interventions.

Cannabis Information and Helpline 1800 30 40 50

<http://ncpic.org.au>

NSW Mental Health Info & Services

Provision of information, support and education to people who are affected by the symptoms of mental illness, whether they are a consumer, partner, friend, or concerned citizen.

http://www.sesiahs.health.nsw.gov.au/Mental_Health_Services

New South Wales Government Health Website

Interesting, relevant and broad-ranging information on health issues including publications, links and what's on events for the promotion of health, as well as a search engine for health services in NSW.

<http://www.health.nsw.gov.au>

LEGAL SUPPORT

Aboriginal Legal Aid

We are predominantly a criminal law practice which provides advice and representation for both Indigenous adults and young persons. In addition, we provide services in child protection matters.

Tel: (02) 8842 8000

<http://www.alsnswact.org.au>

Intellectual Disability Rights Service (IDRS)

A community legal centre working with people with an intellectual disability to exercise and advance their rights.

2C/199 Regent Street, Redfern. NSW 2016

Tel: (02) 9318 0144 **Free call** (NSW, outside of Sydney): 1800 666 611

24/7 support or legal advice for people with intellectual disability in police custody:
1300 665 908

E: info@idrs.org.au

<http://www.idrs.org.au>

Legal Aid

Free legal aid, advice and other legal services to disadvantaged people by phone or face to face.

Phone help for everyone: 1300 888 529

LawAccess NSW is a free government telephone service that provides legal information, advice and referrals for people who have a legal problem in NSW. (9am to 5pm Mon to Fri)

Youth hotline: 1800 10 18 10 (9am to midnight weekdays, 24 hours Fri to Sun)

Legal advice for young people who have committed, or are suspected of committing, a criminal offence.

Tel: (02) 9219 5000 **TTY:** (02) 9219 5126

<http://www.legalaid.nsw.gov.au>

Mental Health Advocacy Service

The service is part of Legal Aid NSW and provides free legal advice and assistance about mental health law. They represent people in hearings that relate to their detention and treatment in hospitals and the community, and the management of their money.

Level 4, 74–76 Burwood Road

Burwood NSW 2134

Tel: (02) 9745 4277

<http://www.legalaid.nsw.gov.au/asp/index.asp?pgid=514>

Warringa Baiya Aboriginal Women's Legal Centre

A community legal centre for Aboriginal women, children and youth living in NSW focusing on issues relating to violence against Aboriginal women, children and youth.

Tel: (02) 9569 3847 / 1800 686 587 (Outside Sydney)
<http://www.warringabaiya.org.au>

Women's Legal Services (WLS) NSW

WLS IS Funded by the Commonwealth and State governments to provide a free community legal service for women in NSW. Services include: Education and Training, Committees and Consultations, Policy Development and Law Reform

General Advice Line

Sydney Advice Line: 02 9749 5533 **Rural Free Call Line:** 1800 801 501
TTY for deaf and hearing-impaired women: 1800 674 333

Indigenous Women's Legal Contact Line: 1800 639 784

Domestic Violence Advice Line

Sydney Advice Line: (02) 8745 6999
Rural Free Call Line: 1800 810 784 **TTY Line:** 1800 626 267
General and Domestic Violence Advice Lines are open 9.30am–12.30pm and 1.30pm – 4.30pm Monday, Tuesday, Thursday and Friday.
Tel: 02 9749 7700 **E:** Womens_NSW@clc.net.au
<http://www.womenslegalnsw.asn.au>

MEDICATION INFORMATION

Pharmaceutical Benefits Scheme

Information available about drugs listed on the Pharmaceutical Benefits Scheme (PBS).
<http://www.pbs.gov.au/html/consumer/home>

National Prescribing Service

We are an independent, non-profit organisation providing medicines information and resources for consumers, health professionals, members and stakeholders involved in quality use of medicines.

<http://www.nps.org.au>

Consumer Health Forum

CHF is a peak organisation providing leadership in representing the interests of Australian healthcare consumers working to achieve safe, good quality, timely healthcare for all Australians.

Tel: 02 6273 5444 **E:** info@chf.org.au
<http://www.chf.org.au>

PUBLICATIONS & INFORMATION – SEXUAL ASSAULT & DOMESTIC VIOLENCE

About Date Rape

Date rape information website; sections include finding help, tips and stories. Set up by the NSW Attorney-General's Department Crime Prevention Division to provide information and resources about date rape to girls who may have been assaulted, their friends and family.

<http://www.aboutdaterape.nsw.gov.au>

Australian and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA)

Dedicated to community protection and safety, through the promotion of professional standards, practices and education in sex offender management, treatment, assessment and research.

<http://www.anzatsa.org>

Australian Centre for the Study of Sexual Assault (ACSSA)

Provides current information on sexual assault in order to assist policymakers and others interested in this area to develop evidence-based strategies that respond to, and ultimately reduce, the incidence of sexual assault.

Tel (03) 9214 7888

<http://www.aifs.gov.au/acssa>

Child Sexual Abuse Prevention Network

Global networking page for professionals from around the world working to prevent child sexual abuse, designed to share resources and contact information.

<http://childsexualabuseprevention.wikispaces.com>

DV Help Online

Supports the ongoing development of Domestic Violence Network resources in the Penrith LGA and across the region including the areas of Hawkesbury and the Blue Mountains. Offers information, resources and links.

<http://www.dvhelppenrithregion.nsw.gov.au>

HURT Project

HURT is an interactive website that is designed to raise awareness about the hidden devastation and family turmoil of domestic and family violence and sexual assault, confronting the shame and investigating the issues from the incomparable perspective of those involved.

<http://www.hurt.net.au>

National Association of Services Against Sexual Violence (NASASV)

Peak body for organisations who work with victim/survivors of sexual violence and who work to prevent sexual violence.

Tel: (02) 9819 7357 E: info@nasav.org.au

<http://www.nasav.org.au>

SADA (Sexual Assault in Disability & Aged Care)

Resource for residential disability and aged-care services in NSW. It aims to provide information, tools and contact points for both managers and direct-care workers in these services.

<http://www.sadaproject.org.au>

NSW TRIBUNALS

The Guardianship Tribunal

The Tribunal has a key role in the protection and empowerment of people living with a decision-making disability. It exercises a protective jurisdiction and facilitates substitute decision-making by hearing and determining applications for the appointment of guardians and financial managers for adults with decision-making disabilities.

Level 3, 2a Rowntree Street, Balmain NSW 2041

Toll free: 1800 463928 **Main switch:** (02) 9556 7600 **E:** gt@gt.nsw.gov.au

<http://www.gt.nsw.gov.au>

Mental Health Review Tribunal (MHRT)

The Tribunal has a wide range of powers that enable it to make and review orders, and to hear some appeals, about the treatment and care of people with a mental illness who fall under the Mental Health Act.

Gladesville Hospital, Building 40 Digby Road, Gladesville NSW 2111

Tel: (02) 9816 5955 / 1800 815 511 (free call) **E:** mhrt@doh.health.nsw.gov.au

<http://www.mhrt.nsw.gov.au>

NSW Trustee & Guardian

On 1 July 2009, Public Trustee NSW and the Office of the Protective Commissioner merged to form NSW Trustee and Guardian. This body acts as an independent and impartial executor, administrator and trustee for the people of NSW. Responsible for the making of Wills, acts as Executor in deceased estates, manages Trusts and provides Powers of Attorney. They also exist to promote the rights and interests of people with disabilities through the practice of guardianship, advocacy and education.

To access locations state-wide:

Head Office: 19 O'Connell Street, Sydney NSW 2000.

Tel: 1300 364 103

<http://www.tag.nsw.gov.au/Content+Menus/Our+Locations/default.aspx>

VICTIM SUPPORT

Victims Services

Part of the Department of Justice and Attorney General and consists of the Victims Compensation Tribunal, the Victims of Crime Bureau and the Families and Friends of Missing Persons Unit. The three units work together with the Victims Advisory Board to help victims of crime in NSW access services and entitlements to assist in their recovery.

Victim Support Line: (02) 8688 5400

Freecall (regional NSW): 1800 633 063

TTY (for hearing impaired): (02) 8688 5575

Aboriginal & Torres Strait Islander Contact Line: 1800 019 123 (Freecall)

<http://www.lawlink.nsw.gov.au>

Victims of Violent Crime Approved Counselling Scheme

People who have experienced a violent crime within NSW are entitled to some free counselling under this scheme.

Tel: 1800 069 054

REFUGES

Department of Community Services Domestic Violence Line

If you are escaping domestic violence, family violence or other abuse and need to stay in a refuge or talk about your options phone the Department of Community Services Domestic Violence Line

24 hour Domestic Violence Line: 1800 65 64 63.

NSW Women's Refuge Movement

They develop policy and provide information about women's refuges and domestic violence for the community, government agencies and the media. Their website offers access information about domestic violence, women's refuges, Aboriginal issues, children and domestic violence, Non-English-Speaking Background issues, domestic violence and the law

Tel: (02) 9698 9777 **E:** wrrc@wrrc.org.au

Phone for refuge referral across NSW: 1800 65 64 63

<http://www.wrrc.org.au>

City Women's Hostel

Short-term accommodation service for homeless women over 18 years of age who are living with a mental illness. Negotiable fees of \$10 per night.

Darlinghurst

Hours: Daily, 24 hours

Tel: (02) 9360 4881

E: citywomenshostel@iprimus.com.au

<http://www.citywomenshostel.com.au>

Edward Eagar Lodge

A seventy-six bed crisis supported accommodation service to single men and women twenty years and over. Low fees charged for accommodation.

348a Bourke St, Surry Hills NSW 2010

Hours: Daily, 9.30am–4pm (Office), Daily, 24 hours (Lodge)

Tel: (02) 9361 0981 **E:** edward_eagar@wesleymission.org.au

<http://www.wesleymission.org.au/centres/homeless/eelodge.asp>

HopeStreet – Urban Compassion

Works with marginalised people, through programs aimed at empowering people. Employment training for the long-term unemployed, community development amongst public housing residents and Aboriginal people, problem gambling counselling, general counselling and supported accommodation for the homeless. Safe space available for sex workers.

91 Forbes St, Woolloomooloo NSW 2011.

Hours: Mon–Fri, 9am–5pm

Tel: (02) 9358 2388 **E:** admin@hopestreet.org.au

<http://www.hopestreet.org.au>

Stepping Out Housing Program

Supported accommodation for survivors of child sexual assault. Women over eighteen years of age with or without children. Emotional and practical advice provided through Support Workers. Rent is a percentage of income. Leichhardt.

Hours: Mon–Fri: 9am–5pm

Tel: 02 9550 9398 **E:** onfo@steppingout.org.au

<http://www.steppingout.org.au>

Vincentian Village Family & Women's Centre

Crisis accommodation, family service. Single fathers; coupled families with children; single mum with boy in the mix. Women's Service. No current drug and alcohol issues, managed mental health issues. Surry Hills.

Hours: Mon–Fri: 9am–3pm, Daily 24 hours

Tel: (02) 9360 2140 / (02) 9380 2810

E: vincentianhouse@talbot.org.au

Women's Housing Company Ltd

Subsidised medium to long-term housing for single women without dependant children. Rent is 25% of income earned.

Level 5, 74–84 Foveaux St, Surry Hills NSW 2010

Hours: Mon, Tue, Thu, Fri: 9am–4.30pm, Wed: 1pm–4.30pm

Tel: 02 9281 1764 **E:** reception@womanshousingcompany.org

<http://www.womenshousingcompany.org>

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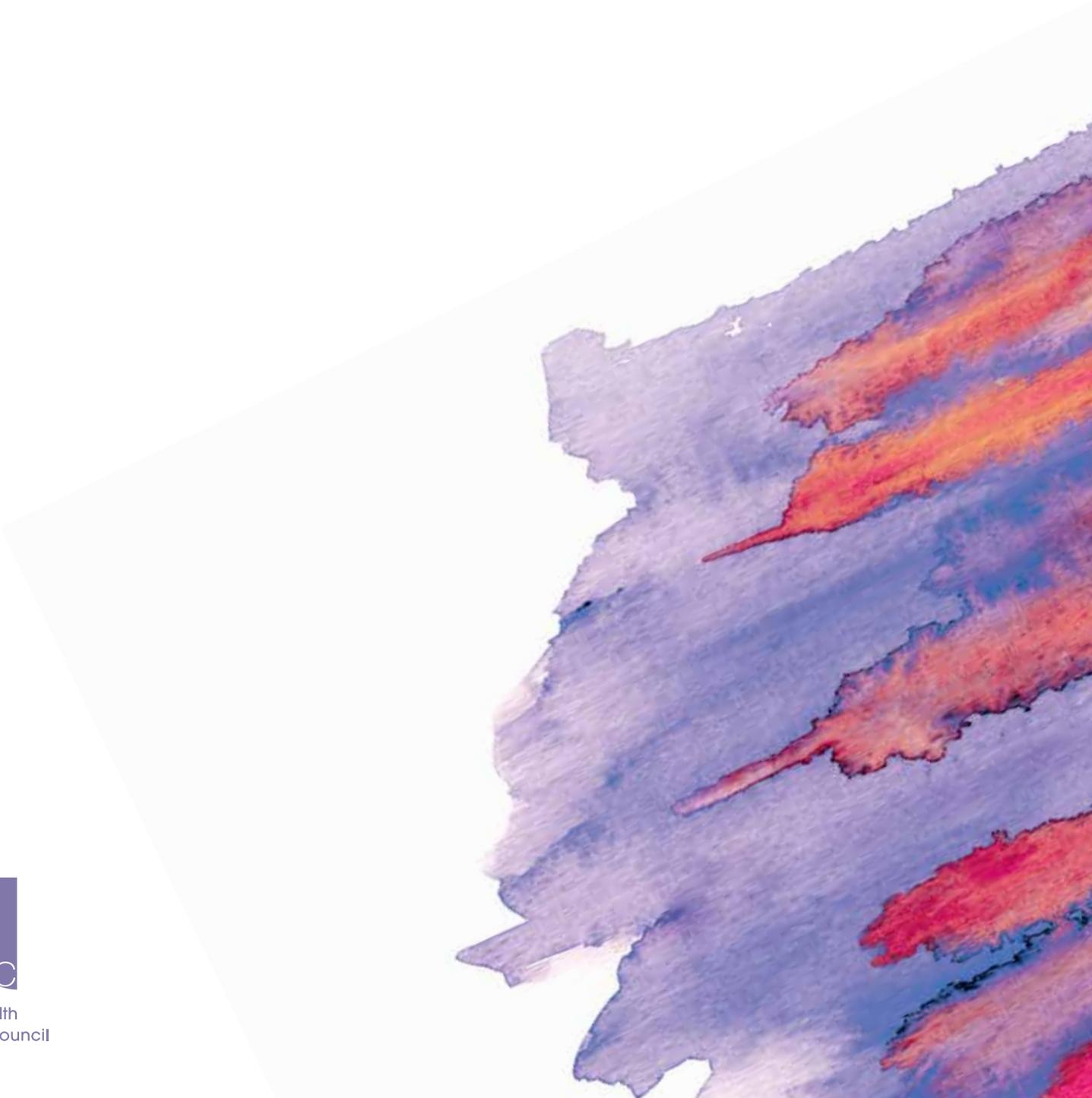
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