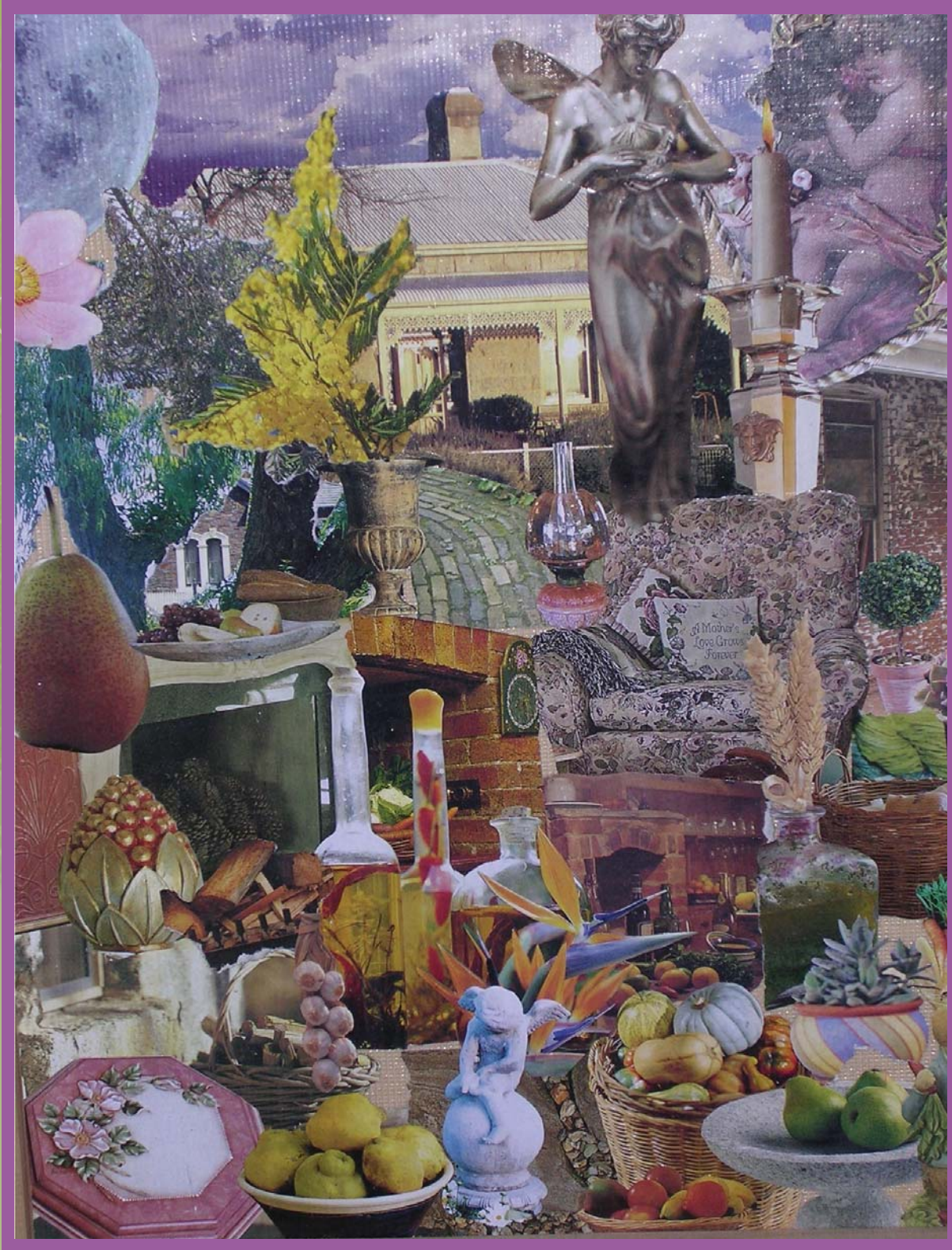


Facilitating Transition



Facilitating Transition

Facilitating Transition after child sexual abuse

Facilitating Transition

after child sexual abuse

Antonia M van Loon RN PhD Debbie L Kralik RN PhD



Royal District Nursing Service
(RDNS) Foundation of SA Inc



Alcohol Education &
Rehabilitation Foundation Limited



Catherine House Inc

Published by the RDNS Research Unit
Royal District Nursing Service Foundation of South Australia Incorporated
31 Flemington Street (PO Box 247), Glenside, South Australia, 5065, Australia
Phone: 61 8 8206 0111 Fax: 61 8 8206 0011
Email: researchunit@rdns.org.au
Website: www.rdns.org.au

Copyright © RDNS Foundation of SA Inc. 2005

Cover: Collage by a research participant

The moral right of the authors has been asserted.

All rights reserved. Without limiting the rights under copyright reserved above, no part of this publication may be reproduced, stored in or introduced into a retrieval system, or transmitted, in any form or by any means (electronic, mechanical, photocopying, recording or otherwise), without the prior written permission of both the copyright owner and the above publisher of this book.

National Library of Australia Cataloguing-in-Publication data:

van Loon, Antonia Margaretha, 1956-.
Facilitating transition after child sexual abuse
Bibliography.
Includes index.
ISBN 1 876563 21 4

1. Adult child abuse victims. 2. Life change events - Psychological aspects. 3. Child sexual abuse.
I. Kralik, Debbie, 1961- . II. Royal District Nursing Service of SA. Research Unit. III. Title.
362.76

This manual is issued on the basis that:

- The information in it is intended as a guide only and should not replace the advice of a healthcare professional.
- The information may be used by you as a starting point for further discussions with advice from your own independent healthcare professional. You should rely on your own independent advice.
- No representation, assurance, warranty or undertaking is given or made as to the suitability of the information for any specific purpose or the relevance, appropriateness, accuracy or reliability of any opinions, conclusions, recommendations or other information (all of which matters may change without notice) contained in this book.
- Save for any statutory liability that cannot be excluded, RDNS and its employees and agents disclaim and exclude to the maximum extent permitted by law all liability and responsibility (whether in negligence or otherwise) for any direct or indirect loss, damage or harm to personal property which may be suffered by any person to whom this book is issued or any other person arising in any way from anything contained in or omitted from this book.
- RDNS does not assume any obligation to update this book or correct any inaccuracy which may become apparent after it is issued.
- Provision of this book does not constitute endorsement by RDNS of any product or organisation referred to in it.
- All information contained in this book is gathered from research participants and the published literature which we believe to be reliable. However we cannot guarantee its accuracy and you should only rely on information and advices provided by your independent healthcare professional. We are passing on this information in good faith.

Dedication

This book is dedicated to all those amazing people who have committed their lives to working with survivors of child sexual abuse, helping them to heal and transition their adverse childhood experiences. Your work is vital and life changing. It has been a privilege to witness such care and compassion in action.

There is a deception present in our society that suffering is personal. This illusion prevents individuals from achieving their potential and stops communities enriching their creative growth. When suffering is shared it provides the space to locate our connections to each other, to the environment, and to the spiritual. When suffering is met with compassion it nurtures those relationships. A healthy, grounded and connected community depends on reciprocal relationships. Thus a community that fails to provide the resources for sharing to take place does so to the detriment of its public health.

Antonia van Loon



Contents

Dedication	3
Contents	5
Foreword	9
Acknowledgments	11
From the Group Facilitators	15
The Photographs	17
About this Book	19
Chapter One	21
The Research Process	21
Introduction	21
Project Aims	23
The Method	23
Demographic Data about the Women Participants	24
Data Generation and Analysis	25
Interview Analysis Process	27
Outcomes	28
Revise CIPP Evaluation Plan	29
Explaining the 'Look, Think, Act' Process	30
Explaining the Cycle	32
A Brief Example Used by the Women	37
Participants Use 'Look, Think, Act' on Their Own	38
Using Collaborative Narrative Group Work	39
Healing Through Narrative Telling of One's Story	39
Using the Book	42

Summary	43
Chapter 2	45
Literature Review and Background Context	45
Introduction	45
History	47
Defining Child Sexual Abuse	48
The Common Story	51
Prevalence of Child Sexual Abuse	52
The Impacts of Child Sexual Abuse	54
Using Narrative Therapy to Surface Somatised Memories	58
CSA and Homelessness	60
CSA and the Legal System in Australia	60
What Happened Within the Survivor's Family?	62
Memories and Flashbacks	63
Disclosure	64
Perpetrators	66
Early Intervention and Prevention	67
Methods of Working with Women	69
Summary	70
Chapter 3	71
Shifting Identity and the Therapeutic Relationship	71
Who Am I As a Person?	71
The Impact of Living with Disruption	73
Sustaining Personal Identity	76
The Impact of Shame on Identity	77
Foregrounding Abuse to Shift Identity	78
Obtaining Support to Shift Identity	79
What Does the Worker Bring to the Therapeutic Relationship?	80
Professional Boundaries within Therapeutic Relationships	81
Reflecting on Your Personal Values and Attitudes	82
Reflecting on Professional Boundaries	83
Barriers to a Therapeutic Worker	84
The Qualities of a Therapeutic Worker	86
What the Client Brings to the Therapeutic Relationship	90
Summary	92

Chapter 4	93
Recognising the Disruption: Looking	93
Introduction	93
The Role of Childhood Family	95
Acknowledging and Naming the CSA	96
Remembering	97
Recognising Disruption	99
Looking: What is Going On?	100
The Worker's Self Examination	100
Questions About the Assumptions Each Person Brings	101
The Use of Metaphor to Make Sense of Disruption	102
The Role of 'Guiding Metaphors' in Sense Making	103
The Therapeutic Milieu	105
Beginning to 'Look'	106
Asking Questions that Facilitate 'Looking'	108
Summary	109
Chapter 5	111
Making Sense of Impacts: Thinking	111
Recognising What Has Changed	111
Asking questions: Starting the sense-making aspect of 'Thinking'	113
Exploring the Shame-Based Identity	115
Using Narrative Questions to Disempower Blame and Shame	116
Some Examples of 'Issues' a Woman Survivor of Child Sexual Abuse May Wish To Explore Over Time	119
Identity and Transition	122
Summary	124
Chapter 6	127
Reclaiming Self: Actioning Transition	127
So What is Transition?	130
Facilitating Transition	136
Action the Catalyst in Transition	138
Summary	143

Chapter 7	145
Suggestions for Good Practice for Service Providers	145
Good Practice re Facilitating Disclosure of Child Sexual Abuse	146
Good Practice re Therapeutic Help	149
Good Practice re Creating a Safe and Friendly Environment.	152
Good Practice re Service Provision	156
Good Practice re Accessibility of Services	158
Good Practice re Community Awareness.	160
Good Practice re Seeking Justice	162
Summary	163
Chapter 8	165
Facilitating transition via group participation	165
The Physical Space for Group Meetings	166
The Process	167
The Facilitator	168
The Participants	173
The Group Dynamics.	175
Summary	177
Conclusion	179
References	183
Appendix A	197
Support Service Phone Details.	197
Crisis Services.	197
Help Lines.	197
Indigenous Specific Services.	199
Social Support	199
Helpful Contacts	203
Useful Websites	209

Foreword

Catherine House Inc. offers emergency and transitional supported accommodation, and a range of services, to women with complex needs who are homeless. Over 93% of the clients that use the service have experienced the trauma of child sexual abuse. As a result, some have used drugs, alcohol and gambling as a means of trying to manage their emotional and physical pain.

Dr Debbie Kralik from the Royal District Nursing Service (RDNS) Foundation Research Unit approached us at Catherine House Inc. during 2002 to consider entering into a research partnership with the RDNS Research Unit. It was recognised in these discussions that one underlying issue for many women requiring support from Catherine House was the impact of sexual abuse during childhood, which appeared to be correlated to their alcohol, gambling and/or substance misuse in adult life. There had been little capacity building research done in this area.

Our two organisations partnered, applied for, and were successful in gaining funding for the study from the *Alcohol Education and Rehabilitation Foundation Ltd. (AER)* and as a result, the project commenced during August 2003 and was completed September 2005. The Project Management Team, which was set up to oversee the project, met regularly and consisted of members of both organisations. The project has proven to be an excellent example of two non-government organisations working collaboratively together, at every level, to achieve very positive outcomes.

This inquiry was grounded in the actual experiences of women who, as children, experienced sexual abuse and have continued to live with disruption throughout their lives. Catherine House is indebted to both Dr Antonia van Loon, the Research Unit's Project Manager who led the project, and Deirdre Flynn, a social worker at Catherine House, for working so sensitively with the women who participated in the study. Together with the women, they untangled life stories that had been silenced. With immense courage, women have shared their stories and told of events and experiences that have shaped and disrupted their lives. They have found their voice, which has risen, sometimes gently, sometimes fiercely, but always from deep within. The process used to help the women share their stories and make sense of their life experiences is elaborated within this book, as a tool to assist service providers working with survivors.

The group process allowed a safe space for reflection and interpretation, and through the research construction, a consciousness-raising developed among many of the women who participated. The growing trust that developed in the group allowed women to gain more confidence and courage about the issues/questions/topics that they were prepared to raise. This was very important as many of the women had held on to these questions and associated anxieties for years. Some women found participating in the group difficult, as they confronted the most painful and shameful aspects of their lives. At times women would need to retreat from the group to process their reactions and feelings before they were ready to come back and do more healing work. At all times, the women were free to come and go as they required.

It emerged during the study that the women's stories of disruption were stories of their feeling different, so that possibilities for order and continuity in their lives appeared to be remote at times. It has been important for the women to hear the experiences of others. The sharing of experiences and knowledge within the group increased the sense of personal validation for each woman. In voicing and sharing experiences a sense of clarity of the past and its impacts developed and a vision for a preferred future was able to be constructed. This movement towards order is not always straightforward, nor does it happen quickly, but rather it is experienced as an unfolding process. The research process of 'Look, Think and Act' provides a process that can facilitate understanding, sense-making, and the necessary action that creates the life-enhancing change which facilitates transition. This book expands this process for service providers. We hope you will utilise this simple process to make available the benefits this work affords survivors as they reclaim their sense of self and reshape their future.

The results of the study show that child sexual abuse has a lasting impact that can seriously compromise a woman's sense of herself, as well as her life chances. It is hoped that this book will be a valuable resource to the many wonderful workers in this field, and that you will use it to assist women with experiences of child sexual abuse to move forward more positively in their lives.

Madge McGuire

Director: Catherine House Inc.

Debbie Kralik

Acting Director: Royal District Nursing Service Foundation Research Unit

Acknowledgments

First and foremost, we are deeply grateful to the women who took part in this research project. The process of discovery we have worked through has taught us all much about ourselves, each other and life. This book highlights the process used to help women to face their experiences and move forward with their own healing journey, transitioning disruption and reclaiming their identity. The women have shared much of themselves and their willingness to do the difficult work of exploring past and present life experiences, has enabled us to explain how this process can be used to help other CSA survivors make sense of their lives.

Some women requested to have their full name in this book. Others asked for their first name only, while others nominated a pseudonym to protect themselves or their family. Participants who were uncertain were provided with a pseudonym to protect their anonymity. Words are not enough to tell you just how grateful and thankful we are to these courageous and amazing women:

Joanne Marie Betts, Roseann Dowden, Louise, Sophia, Catherine, Leilani, Vivian, Anastasia, Maisie, Megan, Emma, Harmony and Grace.

The research team would like to thank the following organisations who participated in the data generation process. We were heartened by the enthusiasm and commitment shown by service providers to participate in this research to improve the capacity of their services to their clients. In total, 50 services were invited to participate and of these, 24 organisations confirmed their response. They were:

Addiction Counselling Service
Alcoholics Anonymous
Baptist Community Services
Catherine House
Centacare Catholic Family Services
Dale Street Women's Health Service

Domestic Violence Crisis Service
Drug & Alcohol Services South Australia
Gambling Addiction Treatment Service
Mission Australia
Offenders Aid and Rehabilitation Services of SA Inc.
Ramsay Health Care SA Mental Health Services

- The Adelaide Clinic
- Fullarton Private Hospital
- Kahlyn Day Centre

Relationships Australia
Salvation Army Social Services
Second Storey Youth Health Service
Service to Youth Council Inc.
Sidestreet Counselling Service
Southern Junction Community Service
StreetLink Youth Health Service
UnitingCare Wesley Adelaide
Women's Health Statewide
Yarrow Place Sexual Assault Service

Special thanks must also go to the following individuals who contributed a lot of time, knowledge and expertise to this book. It has been a joy to work with so many committed and inspiring professionals. The women of South Australia are fortunate to have you all. These amazing people are:

Fiona Barber, Melissa Castle, Sarah Bishop, Wendy Bowman, Denise Carey, Leslye Chenery, Grant Daniel, Cecile Dutreix, Kylie Duncan, Deirdre Flynn, Anna Kroehn, Susan Mann, June Mattner, Julia Mc Millan, Robert Mittiga, Kathy Modystack, Karan Mulvey, Gabrielle Preston, Tanya Stojadinovic, Sandra Taylor, Mary Rumbold, Jody Sloane, Jackie Terryschild, Manja Visschedijk and Mim White.

Please note that the professionals listed above contributed to our understanding of the book contents. Being listed in the acknowledgments does not imply their endorsement of the final content and as such the authors take full responsibility for the final manuscript.

We'd like to thank a generous and sensitive team of professional women from *Women's Health Statewide* – Leslye Chenery, Cheryl Baxter, and Louise Sibenaler who funded and delivered two excellent half day complementary healing workshops at Catherine House as a result of this project. The workshops provided activities the women could use to care for themselves as they dealt with past trauma.

We would like to acknowledge Michael White from *Dulwich Centre* for permitting us to adapt his 'Migration of Identity' graph for use in this resource and the Women's resource '*Reclaiming Myself After Child Sexual Abuse*'. We would also like to acknowledge *Ngala House* for their permission to use the diagram of the 'Cycle of Violence' in the survivor's resource '*Reclaiming Myself After Child Sexual Abuse*'.

Bouquets of thanks to the fantastic support we have had from the staff of *Catherine House* and *Royal District Nursing Service Foundation Research Unit*. They have helped with transcription of hours and hours of taped interviews, administration of the grant, provided professional critique and editing of final manuscripts. Our requests have always been served with dollops of encouragement and mountains of goodwill, and we give our sincere thanks to:

Debbie Kralik, Natalie Howard, Lois Dennes of the RDNS Research Unit and Tina Koch (former Chief Investigator and Director of RDNS Research Unit until March 2005) and Madge McGuire, Deirdre Flynn and the administrative and catering staff of Catherine House.

This important work could not proceed without being resourced, so we gratefully acknowledge and thank the *Alcohol Education and Rehabilitation Foundation Limited* for the grant funding that they contributed to make this project possible. They have been an excellent funding body to work with, making the administration of the project simple and hassle-free.

Finally, I (Antonia) would like to acknowledge my husband Hugo for his active encouragement and constant companionship that sustains and enables me as a person. Having that kind of support allows me to focus my presence in the research process.

Antonia van Loon
Project Manager



From the

Group Facilitators

We have called this book '*Facilitating Transition After Child Sexual Abuse*'. It is aimed at people who work with women survivors of child sexual abuse. It is the companion volume to '*Reclaiming Myself After Child Sexual Abuse*' which is a resource for women survivors of child sexual abuse. The title of this resource makes the claim that a key role of service providers working with CSA survivors, is to facilitate transition.

Transition encompasses people's responses during a passage of change. This change can cause disruption, particularly when the changes are not chosen and produce adverse alterations to one's identity. The experience of disruption is an experience of feeling different. A taken-for-granted way of living has ended. The disruption leads to the life task of finding new ways to live and be in this changing world. The limbo phase that follows the change event is a time of sense making. Here aspects of the former self are reclaimed and new roles, relationships and connections are established. With time and support the CSA survivor locates a sense of coherent and continuous self within her changing world. At this time she moves into a place where life becomes more familiar. She regains a sense of ordinariness that incorporates aspects of the old and forges new beginnings. Transition is an ongoing and dynamic function of daily living, which may be taken-for-granted when the changes are easily amalgamated. However, major or adverse changes create disruption to a woman's sense of self. This is particularly so for survivors who have become homeless, or those commencing the recovery process after addictions, who were the participants in this research. The sense-making activity that takes place during transition can be facilitated by the 'Look, Think, Act' process. The final outcome is a reconstruction of a valued self-identity with which the woman feels able to live.

Joanne, a group participant illustrates:

It started with no self-esteem... being raped... accused... not believed... think I started sliding from there. Every now and then I'd get a charge and I'd try and lift myself out of it. As I got older I could not let things slide off my back as much. When you've got young children, you start thinking... and then came the flashbacks of the abuse, of what my parents were like. I coped by going full on into work or whatever, work, party, drink... it didn't matter. Just as long as I was running ahead of it. I had no idea who I was.

That's what I think the difference is between then and now. I know the past can never get me again. Never! I've done the right down, rock bottom thing. I mean, I had nothing left at all when I came to this place. Nothing! Not a handbag, no self-esteem, not an ounce of my spirit, no light in my torch at all. I was finished with the world.

I still get hurt, but recover quicker now. I don't dwell in that world (sadness) for long. I say to myself 'I've done that, bang, bang, bang... and list it in my head, and no more'. I don't stay there any longer. I get up and get on with it. That was the past and it's done. I don't waste energy feeling shameful and guilty, or beating myself up over it. I put problems in their spots now. It is about growing my self-esteem and knowing more clearly that I am OK. When something happens that really knocks me and takes me back to that self-loathing stuff, I don't dwell there long, because it's really self-destructive. I know how to sort this stuff out now, so I am taking responsibility for myself.

We were truly privileged to share time and testimony with these remarkable women. We trust we have conveyed their message to you regarding their needs and the processes that work best to facilitate their transition from a disrupted past to a healthier future.

Antonia van Loon and Deirdre Flynn
Research Group Facilitators

The Photographs

The participants were given an opportunity to take photographs that represent aspects of the journey through their eyes. The collages on the cover of this book were completed by one of the women depicting aspects of her life that she either values or that have impacted her sense of identity. These explanations accompany the photos at the commencement of each chapter.

Chapter 1

You need a safe place to live to be able to do the work of healing.

Chapter 2

I have found the love of a pet is unconditional. They are safe and faithful.

Chapter 3

Think about the impact

Adrift on a sea, alone and so sad

Crying about all that I've lost

Everyone thinks I am just mad

But love's anchor to me has been lost.

A family secret, dirty, obscene

Stole my spirit, shredded my hope

Took away my childhood dreams

How was I supposed to cope?

I won't let this past hold me back

I am determined to make it change

My children, no love will they lack

My nurture will stay within range.

Anonymous 2004

Chapter 4

I used to hide behind the masks – I gave people what they wanted to see. I am getting in touch with the real me and she's OK!

Chapter 5

If my rabbit does not want to be touched it scratches me to let me know and then I let it go. When I didn't want to be raped within my marriage, I tried to defend myself. I was beaten. I was not left alone. I was treated in a way that I would not treat an animal.

Chapter 6

I am pruning the dead relationships out of my life, so I can get fresh new growth!

Chapter 7

This painting is about me building new connections to people who love me and cutting loose people and things that will poison my life.

Chapter 8

I am seeking protection and nurture in the arms of my higher power.

About this Book

This book was written for service providers of female survivors of child sexual assault/abuse (CSA). We have therefore used the feminine pronoun throughout this text when making reference to CSA survivors. That is not to say that much of the work discussed in this book would not be useful and appropriate to males. We believe all service providers will find benefit in working through this book, but those working with males will have to alter the feminine pronoun as they read. We have spoken about the perpetrator of the CSA as 'he' because in most cases the offending perpetrator was a male. That is not to say that women do not perpetrate sexual abuse, or that males are not the victims of CSA.

The quotations are verbatim extracts from the women who participated in the research and we have not altered the language, which may be colourful and colloquial because it represents the women's life story as they shared it.

We use the word 'survivor' instead of 'victim' because we believe the victims are already dead. They were murdered, or committed suicide, or have become so spiritually and emotionally dead that they are chronically ill, or perhaps institutionalised. These women were victimised as children, but they survived. They are working to shed the paralysing qualities that are part of the 'victim' identity. The emotions that fuel alienation and make them feel like a victim are shame, anger, guilt, fear and embarrassment and these emotions always bring about a level of suffering no matter how great or trivial their cause.

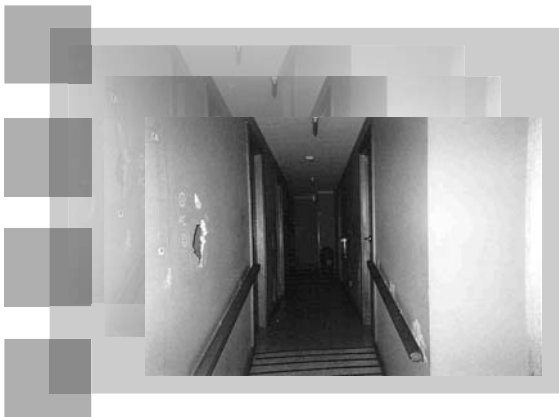
This is not an authoritative text covering the many best practice guidelines for working with CSA survivors to facilitate their healing journey. There are many excellent resources available that have already undertaken that task. Nor is it a description of the impacts of CSA which have also been researched and discussed in a myriad of reports during the past twenty years. Rather than duplicate what is available and known, we have chosen to provide a resource that discusses the process we used in this research. The process is participatory action and many women in this study found

it simple, logical and empowering when they learnt how to use it. We believe it is an available and accessible tool for professional and lay workers to use in practice, as well as survivors, because it helps people make sense of life issues. Women move from surviving to self-determining, increasing their personal agency so they start to create a future more to their choosing.

We recommend that service providers read this volume first and gain an understanding of the method used and the important practices that facilitate successful implementation. Then we suggest you invite CSA survivors to work with you, using the companion volume *'Reclaiming Myself After Child Sexual Abuse'*. The woman should work through that resource one chapter at a time, completing the self-help journaling exercises in that book between individual visits, or within a support group environment. When you meet with the woman, use the 'Look, Think, Act' process with her, so that she explores her feelings, thoughts and emotions. Then encourage her to choose actions that will facilitate her healing and move her toward a stronger sense of self and her preferred future.

Chapter 1

The Research Process



Introduction

'Capacity development is the process by which individuals, organisations, institutions and societies develop abilities (individually and collectively) to perform functions, solve problems and set and achieve objectives' ³. This research focused on social development seeking to integrate various stakeholders, namely survivors of child sexual abuse with alcohol, gambling or drug related problems and their support service providers. Capacity building research invests in people and practices that engage together to achieve development objectives. Investment in people, organisations and practices requires knowledge and time. This research sought to provide survivors of child sexual abuse (CSA) with the time they required to surface their stories and access aspects of their experience that were causing them continuing distress. From this information we want to inform services how they can better serve their clients so the woman's personal capacity and agency is developed.

We believe that the younger the people know about the impact of CSA the better. Many of us clearly remember having anxiety attacks when we were young but we blocked them out. Some of us were hiding by achieving, so outwardly nothing looked like it was going wrong in our lives, BUT it did as we became adults and parents, and tried to get more in touch with our emotions and feelings in relationships with partners and children. It is as if we knew something was wrong when we were younger but we were never able to connect 'What' and 'Why', until we got to this point. Being able to get in touch with the reason behind our anxieties should have started much earlier in our life journey. That meant people needed the courage to confront us about our sexual abuse. We also had to be willing to take the risk and be ready to disclose. Please confront our children in the way we wish we had been supported so they look into themselves, much earlier in their life. It's often too raw to recognise the connection when you are young so you don't accept help, but that does not excuse service providers from attempting to help us. When you are confused and don't know what's wrong with you, how can you pick up the right self-help book, the right pamphlet, ask the right questions, or find the right help?

This capacity building research project was funded by the *Alcohol Education and Rehabilitation Foundation Ltd.* and developed in a partnership between the *Royal District Nursing Service Research Unit* (a division of the RDNS Foundation), *Catherine House* (supported accommodation provider to women conducted under the auspices of Sisters of Mercy) and *Centacare* (Social services conducted under the auspices of the Roman Catholic Church in South Australia). It was commenced because the RDNS Research Unit have a research interest in life and social transition. This work has a special focus on transition and illness; and examination of transition from various socio-cultural perspectives with disadvantaged people and special needs groups across the lifespan. The unit has an excellent track record of working with participants to affect quality outcomes.

The staff at Catherine House were aware that as many as 90% of the women that came through their accommodation had experienced sexual abuse in childhood and this was a trigger to their alcohol, drug and gambling misuse, which in some cases had become an addiction that was contributing directly to their homelessness. These women were supported with their drug and alcohol problems and mental health issues, but few were dealing with the core problem of discussing their experiences of CSA and family violence, which began their trajectory toward homelessness and illness. It was deemed worthwhile to investigate if such women might be helped with their dependencies and addictions, if they had the opportunity to work through issues grounded in their childhood within a supportive group environment. We were hoping that such work would facilitate the women's transition from supported accommodation toward independent living, while improving their self agency.

Project Aims

The aim of the project was to promote capacity building with women CSA survivors and the services they used. We sought to develop a program that facilitated change through action and to disseminate that program in the form of a resource that was sustainable and transferable to similar service settings. The resource would further the understanding of the issues impacting women survivors of CSA who were homeless due to alcohol, drug and gambling misuse and identify the supports they need to transition toward self-management. This resource should promote community capacity to respond effectively to this client group. We sought to bring the main stakeholder groups (women and services) together through a participatory action process toward development and evaluation of such a resource. Through utilising the Context, Input, Process and Product (CIPP) evaluation framework ⁴, we documented the project process and articulated the outcomes, so that both would be transferable to other settings.

The Method

Antonia van Loon managed the project and commenced in August 2003 by gaining ethics committee approval for the study and establishing terms of reference with the project management committee. They agreed on the project plan so it would meet its clarified objectives and prepared the research design collaboratively ⁵. Recruitment strategies were put in place via the social worker at Catherine House who was the first-point-of-contact with the women participants.

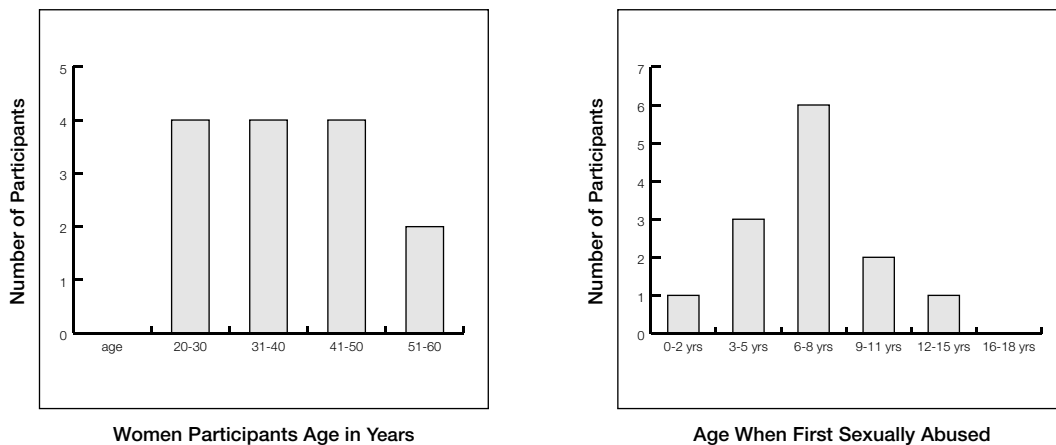
Over 50 service providers were identified and invited to participate in two separate reference groups and 24 affirmed their willingness to participate. Formal consent was gathered and the project aims and details of methodology were shared. Demanding workloads meant face to face involvement had to be rationalised to quarterly meetings with email feedback between meetings. These strategies enabled workers to participate without significantly increasing their workloads.

The service provider group commenced the meetings by reviewing particular issues raised by the two CSA survivors groups in their discussions. Additionally, service provider participants were asked to give 'The Top Five Issues' affecting their practice when working with CSA survivors. During each meeting additional issues were raised from participant groups and discussed. These points were collated and placed into a feedback document which was circulated by email to all participants for further reflection and possible action. Additionally, the discussions from each meeting were analysed and coded into themes, which were sent to the group with the meeting minutes for their consideration and action.

The women wishing to participate were recruited via the social worker at Catherine House, Ms Deirdre Flynn, who dedicated one day a week to this project. Two groups of eight participants were invited to join the research. The complex nature of the social and health issues experienced by these women, and the sensitivity of the topics discussed, meant that large groups were not feasible. Many women had been isolated for lengthy periods due to their addiction and/or homelessness and were mistrustful of discussing sensitive issues in groups where they may be judged by others. Participating in group work was a significant challenge for most. To facilitate the development of trust and allow each woman a comfortable space in which to unpack and share her story, it was decided to limit the groups to eight participants. Three women withdrew from the groups for various reasons. One woman moved interstate; a second shifted a distance from Adelaide making fortnightly travel expensive and thus problematic; a third obtained full time work early in the research process so was unable to continue.

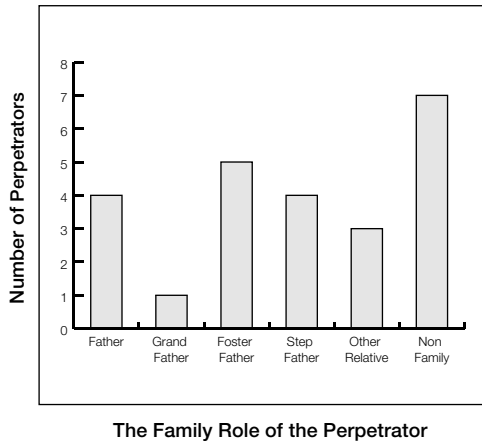
Demographic Data about the Women Participants

The ages of the women varied with the youngest being 22 years of age and the oldest 54 years of age. The women in Group 1 were mostly over 40 years and in Group 2 they were under 40 years. An alarming 80% of the women had been sexually abused by more than one person during childhood. Of the thirteen women who could recall the age at which the abuse started, most were between the ages of 6-8 years.



All the women interviewed mentioned suicidal thoughts and most had stated they had made at least one suicide attempt. Six women stated they had multiple suicide attempts requiring periods of hospitalisation. All the women practised at least one or more of the following risky health behaviours: drinking excessive alcohol, using illicit drugs or substances, self-harm and gambling.

Two women did not have children, two had one child, five had two children, four had three children and one had seven children. At least four said they had worked within the sex industry and eleven described themselves as having been very sexually active during adolescence.



One participant was born in New Zealand, one was born in the United Kingdom, one was from an Italian family but Australian born, and two were Indigenous Australians. The remaining women were Australian born. More than half the women had spent their childhood in rural and remote areas.

Most women reported having had more than one CSA perpetrator during their childhood years. Of those perpetrators discussed at interview, 22 were male and 2 were female. The first CSA perpetrator was most often a family member, and most commonly a biological, step, or foster father. Additional perpetrators were most often extended family members, step brothers, uncles and grandparents. There were three women who were sexually abused whilst in the care of the State. Only three women had proceeded to court to prosecute the offender/s and of these, only one secured a conviction after which the offender was imprisoned for their criminal action.

Data Generation and Analysis

The principles of Participatory Action Research (PAR) ⁶⁻¹³ were utilised when researching with service providers. Using the process of 'Look, Think and Act', service providers named their problems/ issues, decided what could be improved and considered ways to action their decisions. Meeting proceedings were recorded and analysed and feedback was given before further discussion took place ⁶.

The data generation with the women participants commenced with individual interviews in September 2003. After obtaining informed consent, it was emphasised that each woman should feel free to say what she wanted to about her past, in whatever manner she wished to speak about it. She did not have to provide detail about her sexual abuse unless she felt she needed to speak about it. Interviews were audio taped, transcribed and analysed. Each woman was assured that her identity would be protected in the subsequent documentation, and only common issues and actions would be reported to the PAR group. The interviews commenced with the question *'Tell me your story from your earliest memory of being sexually abused as a child and explain the ways you think this has influenced your life'*.

These face to face personal interviews with each woman were essential because of the extremely sensitive issues that each woman raised. It was important that each woman knew that her story had been heard, understood and believed by the researcher, so the woman could trust her to help manage discussions and interactions within the group. The interview data enhanced understanding of the issues impacting women and it became evident that although details of abuse differed, there was a common story around the impact the sexual abuse during childhood had on the women's lives.

Counselling was available from the social worker at Catherine House for the duration of the project, as she followed up each participant within 24 hours of the initial face to face interview, to offer support. The research team recognised that foregrounding abuse and giving voice to abuse experiences was difficult. Almost all the women shared that it was the first time they had disclosed their sexual abuse to anyone. This was most disturbing given that each participant was seeing a professional (or several) for therapy. Some had been seeing counsellors and psychiatrists for periods varying between 1-14 years! Some women said they had never been asked, so they had never told. It appeared that asking to hear the woman's story about the impact of CSA gave her permission to give a voice to her childhood experiences. Needless to say this was coupled with a readiness to speak about such difficult and painful incidents. Each woman told her story with great courage. The interview processes required careful and sensitive facilitation that included authentic listening and genuine empathy.

Each woman was offered free ongoing counselling support from Centacare if she became distressed or uncomfortable at any time during the research process. At the conclusion of the interview, the women were invited to join the group sessions to continue their disclosure and commence the healing process, as long as they felt comfortable doing so.

It is important at this point to acknowledge the difficulty in hearing such traumatic stories. As a researcher I felt a strange blend of emotions and feelings. They were a perplexing blend of sadness,

heaviness of heart and outrage over what these women had experienced, combined with a sense of privilege at being trusted with such intimate and painful life stories, and awe and admiration for the women's strength. I had expected to feel a mix of emotions because I had read about the concept of vicarious traumatisation in my pre-reading on the subject in preparation for the research activities^{14, 15}. However, I did not expect the level of intrusive thoughts and images that kept me dreaming for many nights following some of the meetings, interviews and transcript analysis. To prevent these intrusive thoughts from interfering with my ability to be useful, I managed them by debriefing with a colleague in the research team. I spoke with the social worker supporting the women from time to time to check my own functioning. The most useful personal tool I utilised was regular meditative reflection, introspection and prayer for each woman participant and for me.

Interview Analysis Process

Each interview was between 1-2 hours duration. Analysis was a lengthy process because each transcript needed to be read through 2-3 times to gain an understanding. The woman's thinking was often disjointed where she jumped back and forth from the present to the past. To find the natural meaning units expressed by each woman and to follow the threads throughout the interview was a longer process than anticipated. The words were reworked into biographical statements using each woman's own language to find meaningful quotes that substantiated interpretations used in the text.

The transcript themes were grouped into concepts, again using the women's language. These themes were put together into a 'combined story' that created the starting point for our group work. Each interview was analysed to locate:

- The positive strengths each woman displayed with which she could potentially move forward.
- The specific needs/wants of each woman uncovered in her interview.
- The negative thoughts and feelings generated by living with a past history of CSA and their ongoing impact.
- The broader issues generated by the need to change lifestyle and coping methods to self-manage addictive behaviours and past life experiences.

All the lists were combined and common themes clustered which became the starting point for the PAR process.

The group used the 'Look, Think and Act' process developed by Stringer ¹⁶⁻¹⁸ to identify and name the issues confronting them and learn when and where to find help. Trust was imperative to effective group function and discussions that were supportive and helpful. Each woman saw in another woman's story aspects of her own and this removed the isolation that most women expressed was one of the key debilitating effects of CSA. Meetings were held fortnightly to enable transcription and analysis of meanings using the participants' own words. This information was collated into themes and written up and posted back to the women to promote reflection and thinking before the next PAR group. Women were encouraged to re-read the document and start thinking about what they may like to act on at a personal level. Sometimes this was possible and at other times they just could not re-read the work.

I don't think the reasons have disappeared, the reasons will always be there. But the way I have storied those within my head has changed. I think what I used to treat with contempt, rebellion and anger has changed into something else. I have become more patient and compassionate with myself and others.

In keeping with ethical research, key values permeated every aspect of this project. First, was that the researcher was a vehicle to ensure each woman located her voice and heard her own story. Second, that the group's collective voice was honourably and accurately put into print form. The aim was to help survivors and service providers understand their experience and responses to such extreme violation, so survivors could move from a victim identity to a coherent sense of self with personal agency.

Outcomes

The women said that their desired outcome from this project would be a self-help resource that could be used to guide group discussion and personal reflection. This was not a planned outcome of the research proposal, but in keeping with the tenets of participatory research the participants guide both the outcomes and the process. Thus we accommodated this request and began the process of developing two separate but complementary and supplementary resources. The women said the resource for service providers was to be aimed at helping them understand what was going on for a woman who had experienced CSA and how they may effectively work with these clients. The information was collated from interviews and group work around significant themes that surfaced within the group, which were developed and explored by the four distinct groups of women and service providers.

The public do not want to face the fact that child sexual abuse happens. They are too horrified, shocked and stunned and don't know what to do, so they pretend it's not happening in the world that they live in. People in abusive families are ashamed and try to deal with it within the family so they don't lose face or get embarrassed, so the damaging cloak of secrecy continues. We want to diffuse the mystery around this whole dirty subject and help all people see the impact. Our lives have been a living hell and if one good thing comes out of it, like these resources from this project, then that will at least be something positive for all the pain. We think raising public awareness will help make people confront it, so they (the perpetrators) can find nowhere to hide.

Revise CIPP Evaluation Plan

The evaluation of this project is entwined with project implementation utilising the CIPP model ¹⁹ which compiles information for decision making via description and analysis of components: Context, Input, Process and Product hence the acronym CIPP²⁰.

Context evaluation describes the participant group(s) and socio-political environmental conditions in which the project was undertaken. Indeed the topic of child sexual abuse has not been out of the news in South Australia since this project commenced. We anticipate our findings will inform current discussions, as the voice of homeless women is not clearly articulated in the current debates regarding service/treatment options for this client group.

Input data meant that all stakeholders were consulted and decisions recorded and analysed. Context and input evaluation provide a clear articulation of the operational aspects of processes. All stakeholders provide input as to what should go into the final resource and why and how it should be presented and used. Further, consultation of the literature and/or expert sources were undertaken to inform the resources.

During *Process (formative) evaluation* we examined the type of resource that would be most useful. Whilst undergoing the process evaluation stage the Project Manager consulted with stakeholders and service providers. Women participants were asked to provide information about the services they required and found useful.

Product evaluation, the last component of the CIPP framework, highlights the project's attainments during and on completion to show the project's objectives were met. Outcomes or products of the project have been (1) the report, (2) the women's self-help book '*Reclaiming Myself after Child Sexual Abuse*', (3) the service provider resource '*Facilitating Transition after Child Sexual Abuse*',

(4) journal publications, (5) professional presentations as listed, and (6) the accompanying research report from this project 'Promoting Capacity with Homeless Women Survivors of Child Sexual Abuse Misusing Alcohol, Drugs or Gambling'. These products have transferability and utility for other settings and can be accessed from www.rdns.org.au/research_unit.

Explaining the 'Look, Think, Act' Process

Looking

During this phase the woman builds a picture based on information available to her about the issues confronting her. From here she locates the areas she wants/needs to work on to move forward. She is encouraged to take some time to:

I've read the transcripts and I've actually got upset, because I think, 'Oh, my God! These things have happened to me too! I'm not alone any more, there are other people who've been through this too'. It was really in my face and up front of my mind, but none of it was clearly thought out. I've given it more thought now and I'm making some sense of how it's affected my life.

- *Describe:* What is going on? The circumstances.
What's happening inside of her? Her responses.
- *Gather information to build a picture:*
Who: the people involved;
Where: the place; and
When: the time of the situation.
- *Record the information from her experiences:*
Try to get other people's views.
- *Describe the context of what is happening:*
What thoughts are going on in her head?
How long is she mulling over an event afterwards?

Thinking

She aims to clarify meaning and increase her understanding of the why, when, what, where, how... of her experiences. Describe the issues and think about what she needs to do with/about them. She can ask herself questions like:

- What's the main problem?
- Why is this happening?
- What was the trigger or cause? (Eg attitudes, beliefs, past experiences)

- What are the consequences?
- How is she behaving? (Eg are her responses defensive grounded in her past)
- Which area/s can she move forward with?
- How might my moving forward look?
- When should she begin? What order...? (she decides but she may clarify her decision making with your questions)
- How should she do it?

Some weeks everything seems like just a big mess in my head and the group helps me find some peace, I can sort things out in my head. I can listen to how others do things and work things out, and I can talk it through. At other times it's nice to just sit back and watch and listen to other people.

Actioning

Thinking about change does not effect change. She can spend a lot of time thinking about what she wishes things were like without actually taking the step toward making change happen. Actioning requires her to become involved with her current situation and choose actions that take her toward her chosen goals. Often there is little choice about the need to change, and one can only choose how they will change. A good place to start is to think about what could/should be done differently to achieve the outcome she desires. Then she may begin to action the smallest and most easily managed act that would have the most benefit to her happiness and wellbeing.

She sets herself personal goals and tasks, and then works out how she will take action on the changes she wishes to make. In this step she makes an action plan and starts the action steps that will help her to achieve her plan.

- What area/s does she want to act on first?
- What is most important to her right now?
- What is the most achievable thing she can act on right now?
- What's the likely outcome of the action?
- What places will help her achieve her goal?
- Which people can help her?
- Where can she get support if she needs it?

The hardest part is starting. It's like riding a bike, you have to get on first and then you fall a few times, but you get back on again until you get a feel for the balance, so you know how to correct yourself, keep upright and move forward.

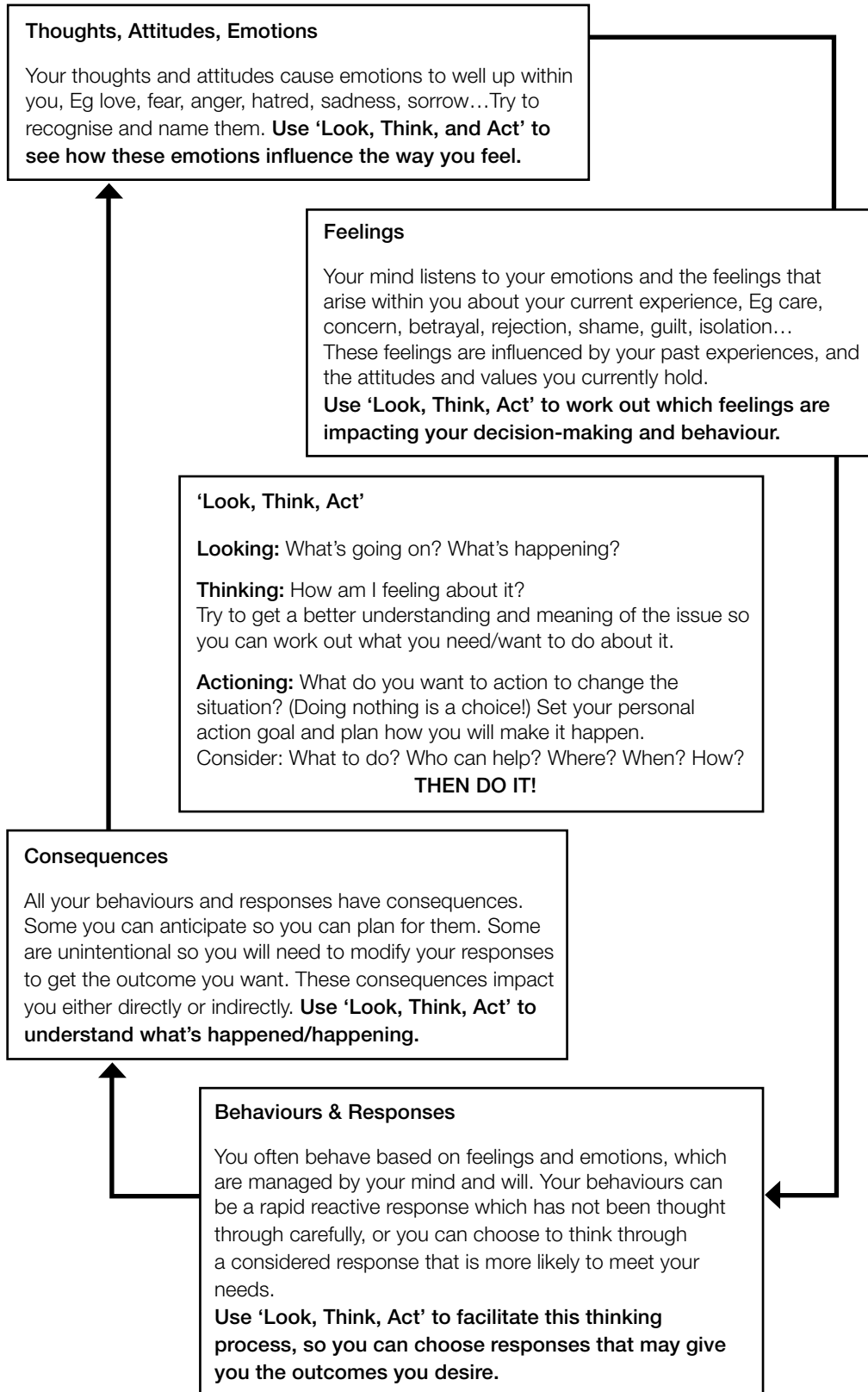
Explaining the Cycle

All humans have thoughts, feelings and attitudes that go on inside their heads about their current experiences. These thoughts and feelings give rise to emotions such as love, fear, anger, hatred, sadness, sorrow, which need to be recognised, acknowledged and if possible named. Those emotions can trigger within people particular behaviours and responses that are based on past reactions when similar emotions were triggered under different circumstances. In the case of CSA survivors their past abuse experiences taught them to respond in ways that were helpful in childhood, but may be less useful when they transition into adult life.

All behaviours have consequences, whether they have been thought through, or not. These consequences impact other people, situations, or impact within us. Some consequences can be anticipated and some are unintended. Regardless of the consequence, each person experiences or deals with the direct or indirect impacts of their behaviours. This process goes on within our heads all day, every day. People modify their behaviours by the reactions and results their behaviours provide them. People can become confused if the outcomes of interactions are not what they thought they would be. The 'Look, Think, Act' process is a simple tool to help the woman work out what's going on when this occurs. 'Look, Think, Act' focuses on changing thinking, so we can see choices in future behaviours and responses, and action those choices to obtain different outcomes under similar circumstances. This simple process facilitates the important life function of maintaining and nurturing a coherent sense of identity or self, within changing and ambiguous life circumstances.

Figure 1.1

Thinking, Feeling, Responding and the 'Look, Think, Act' Process



A Scenario from the project to demonstrate the 'Look, Think and Act' process

This scenario is an annotated brief from the group discussions where we used 'Look, Think and Act' to work through a chosen issue to help the woman make sense of her current situation. A group member is struggling with several relational issues that are creating great anxiety, which is affecting her ability to cope, and sending her to the edge where she wants to use drugs again. The key issues are whether she should leave a risky intimate relationship; problems with other residents; son moving further away from her.

Her Thoughts / Feelings / Attitudes (the woman's words are in quotation marks)

- You are feeling very *'tired'* and *'shaky'* from all the stress you are under.
- You *'cannot eat'*.

I've been very shaky actually. And I'm doing my damndest to keep thinking, but I am so tired. Actually it's partly phone calls and a lot of other stuff... I'm hanging in there, just, very just. I can't eat. I don't want to eat. See, I've been off my tablets for six weeks and I've lost lots of weight...

- You feel *'unaccepted'* by other residents and feel as if they are *'keen to bring you down'* when they are down, *'so they have company in the pit'*.

This person is down in this hole that she can't get out of and everyone around her is getting on with what they have to do. But this person is still down here and she hasn't taken that first step to get better. When she's seeing all these people getting on with it, she's trying to get everyone back down with her.

- You feel *'out of control'*, your *'confidence is shaky'*, due to *'bitchy behaviour'* from other women.
- You feel *'disappointed'* with your progress and the current setbacks in your relationships.

It's just that I felt like I was accepted, like unconditionally loved by someone who's a friend. And then all of a sudden she's turned and I don't know why...

- You are *'uncertain'* about how to position yourself in a relationship because you do not feel on equal ground with them. You said you are either *'putting them on a pedestal'* where you have higher expectations of them, or you have been *'too accepting of them'* and you have not placed the expectations high enough.

I'm just too accepting. 'Oh, no, that's okay, I'm not perfect either...' and then you realise that not everyone else has the same morals as you do. Not everyone else is accepting and it's such a shock. A lot of people would like nothing better than for me to be in the gutter.

Emotions

- You are experiencing 'Anxiety' over role changes as a mother.
- 'Fear' over your changing situation, which is beyond your control. Fear because a previous partner is being intimidating all the time.
- 'Concern' for your son's safety when you are not nearby to 'protect' him.
- 'Angry' over the other residents' inability to see your situation. Angry that they demand more from relationships than you are ready, or able, to provide at this time.

I just felt all this anger and it gets to you. One of these days... I'm trying so hard not to beat the crap out of someone, because I'm so angry. I feel like a fight and I haven't felt like one for 18 years.

I'm angry with myself that I let things happen. I get angry at my weaknesses that I'm trying to overcome. That gets harder and they're stronger than I am and I can't get rid of them. I'm angry at myself for not being able to keep up to the standard of what's expected, or that I want to be at...

Behaviours & Responses

- You have stopped eating. You say this is because 'at least that is something you can control'
I can't control anything else, but I can control what I put into my mouth. If you're feeling low and if things aren't working out and things are just all over the place and your mind is really confused and your body is exhausted, you can control food. It is a good feeling.....it's a really good feeling. I can still do it – to not eat. I am proud to be able to not eat for 14 days, three weeks and just drink, live on coffee and cigarettes and fluid. Eventually you don't count the days any more.
- You have had a reactive response when you saw someone recently who has wronged you in the past and it has surprised you how much anger you still harbour.

And I'm really angry about lots of stuff. I mean, it all comes out of me. I went down to the soup restaurant place, you've probably heard about it. I lost my temper with someone who stole my car a few years ago. I was quite cutting and I tipped my hot coffee over him, just like that. I mean what was I thinking... or maybe I wasn't thinking... or I would not have done it.

Consequences

Anticipated consequences: that you would be accepted... which did not happen.

Unintentional consequences: shock over response by the person you were with, who now sees you differently, but does not know the background to your reaction.

So I suppose she got a bit of a shock. But I wasn't expecting to see him there. And ever since it's like that "Stay away from me, you're not a safe person – you're crazy... not the person I thought you were". It's bizarre.

Look, Think, Act

The woman is encouraged to look at what is happening and to think about what she would like to do about her issue. The facilitator and the group ask questions and offer support, comments and suggestions, but the woman clarifies her interpretation of the situation and decides what actions she will work towards.

Look: Who, What, Where, When, Why

- **Who:** self, friends, son, former partner
- **What:** being accepted, finding equality in relationships and setting and maintaining boundaries, feeling more personal control
- **Why:** deep desire to be supported, accepted and respected, loved and not judged
- **When:** by working out appropriate boundaries and demonstrating open and honest communication about your needs
- **Where:** in relationships

Think: Clarify meaning and describe the issue more fully to work out what you need/want to do about it.

- **How:** You want to relieve the fear and stress of bad relationships and re-story your past experiences to demonstrate to yourself, your son and friends, that you can be an equal partner in a friendship.

Act: Action goals and plan to make it happen.

- **Which people can help?** This group, by sharing the stresses and working through solutions and management strategies
- your son – keeping in touch and working out strategies to communicate long distance
- yourself – working out assertive and positive choices in your arrangements with your former partner, your friends and your son.

What actions?

- Putting in place boundaries re relationships
- Practising assertiveness and open communication

- Establishing boundaries around other aspects of your relationship that may hinder success
- Specifically discussing with your son what he needs and putting in place practices that will achieve your relational goals over a longer distance
- Eating small nutritious amounts regularly
- Practising stress management strategies you used in the past (exercise bike)

What time? Immediately

Needless to say the externalising discussions around this summary (which can be noted in a journal so the woman remembers what she has chosen to action) were extensive. They continued for more than an hour and across several weeks. The woman separated her issues so she could see how they were linked and how each affected the other. She chose actions that were likely to improve her assertiveness, boundary setting and return her personal power. As she regained self control her eating recommenced. Using the 'Look, Think and Act' process takes practise. It helps to use various scenarios from each woman and over time the participants may see the value of the tool and how they can personally use it. Invariably some women use it and others reject its use for their situation. That is a choice. Processes of change are processes of trial and error. When women have learnt the process they may engage it later.

A Brief Example Used by the Women

My son says something rude to me (Behaviour). I think 'How dare he speak to me like that...'
(Thoughts). The emotions I feel are annoyance, frustration, even anger (Emotion), so my immediate reactive response is to shout a 'put down' response back to him (Response). He turns around and gives me a rude gesture and walks off (Consequence). I become more irritated and angry (Emotion), and the episode escalates out of control. The self-talk in my head is 'I'll show you who the boss is! I won't let you treat me this way' (Thoughts) and that drives my reactive response to give him a smack (Behaviour). He turns around and hits me back (Consequence) etc and the cycle of violence and anger escalates. Alternatively, I can stop myself and think 'What sort of outcome do I want from this interaction?' Then choose a response that will most likely achieve the desired behaviour.

The women were encouraged to step back and take a more considered response that might diffuse the situation and shift the outcome. It takes practise but each time they do this it becomes easier. The 'Look, Think, Act' process informs their choices and helps them work out what they want to modify in their thoughts, feelings, attitudes or behaviours and helps them choose responses more thoughtfully.

Pretending that nothing is happening, not responding, or running away, is a choice and the consequences still occur from those choices. That is not to say that withdrawing to think or regroup is not a valid choice, it certainly can be a safe and useful choice. However, ignoring or pretending nothing is going on, decreases the woman's ability to influence the outcome, yet she will still have the consequences of doing nothing.

Participants Use 'Look/Think/Act' on Their Own

If a client wants to work through an issue she has to *Look* at all the options and ask herself questions like 'What's going on in this situation?' She can be guided to consider the what, why, when, where, how questions for each phase. This approach helps to prevent her dwelling with issues by looking and thinking but not actioning.

Think, 'What are the feelings and emotions rising within her over the situation?' 'What is the ... (replace with the emotion eg hate)... having her think about herself?' 'What is it she really wants to do, or can do, that would be self-nurturing?' 'How will she achieve what she thinks is most important

I am working to keep going forward, but I have to change the way I am thinking. My whole perspective of things going on in my life over the past has to change for me, and then those changes need to solidify into permanent positive responses.

I have given myself a list of who I would like to be. I would like to be honest without hurting. I would like to be straightforward, without being too abrupt; to love freely without having a fear of being rejected, and if I was rejected, to take that on board and carry on, to not let it change me and make me bitter.

now?' She should ask herself 'If I do this, then what is the most probable outcome?' The 'Look, Think, Act' process facilitates this self-talk by providing a framework to externalise those facts. For it to be an empowering process the woman takes the chosen action. First she gives expression to the issue and looks at it objectively as if she were describing a chair in the middle of the room. She examines the issue from many angles, thinks about the problems and works out what she wants to do with it. Does she want to take the issue back inside of her? Does she want to share it with somebody else like you, her worker, so she gets help working through it? Does she want to leave the problem with whomever she feels it belongs to? This approach is not easy and it does take practise, but when the woman works through issues systematically using 'Look, Think, Act' it becomes easier. Remember it is not enough to only *think* about possible action, she has to make an attempt to do it, if the situation is to change. This simple process really works and it is a joy to see a woman's

face and demeanour when she has successfully undertaken even small actions and obtained the outcome she hoped for. Therefore it is useful to try the process on simple needs at first, and then keep practising until this way of working through issues becomes more habitual.

Using Collaborative Narrative Group Work

The 'Look, Think Act' process uses a narrative framework to facilitate the sense making activities of therapeutic conversations about issues the woman perceives to be important. Narrative is more than retelling a story. It is a vehicle to make sense of life because one has conversations about aspects of life that matter the most ^{21, 22}. It is a therapeutic conversation because it can facilitate the quest for meaning and identity. The experience of 'self' is denied by the mundane experiences of everyday life in which an individual notes and witnesses their subjectivity (that is the knowledge and experience by which a person understands and interprets their external world) ²³. It is in the public recognition of the self that identity is shaped as socially significant aspects of that person are recognised and known by others. Constructs such as status, roles, gender, position and aspects of the self that are described as 'the social me' are the overarching themes of such conversations. It is in these narratives that people see themselves. The identity explored by narrative is not the psychological sense of the person's essential continuous self. Rather it is the way people see themselves as they are within a social group and how they believe others view them within those relationships. Life becomes organised around such construction, reconstruction or abolition of identity within the significant social groups that help shape us by the use of varying social power dimensions ²³.

I need help to know who I am and where I am going. I have no idea. I can't see myself as anything. I lost my sense of direction and I need someone to show me who I am, so I know which direction to head.

Healing Through Narrative Telling of One's Story

Telling and exploring one's story can facilitate healing ²⁴⁻²⁶. It provides a way of accessing and expressing embodied distress ²⁷. Healing is about dealing with aspects of the story that impact identity, it is not necessary to recount lurid details of the assaults and abuse ²⁸. One's story is a reflection of how that person sees themselves and others or how they wish others to see them. It provides an opportunity to organise and display one's real self so there is a sense of coherence and growth in one's identity ². Narrative allows the experience to move from the subjective internal realm to the objective external realm, so it can be examined and incorporated. Such externalising conversations facilitate transition and build personal capacity ²⁹. When the women heard and saw their story portrayed in words and in print it gave the story a legitimacy and specific moral authority.

I have been here for six months and in that time I kind of believe the hardened shell I had around me about talking about these things has cracked a bit. It was really hard at first, but since the shell cracked it has been a real release of a lot of pain and pressure within me.

In the group we prepared the women to witness stories and to acknowledge one another's experiences. We paid attention to what was said. Each woman was asked to think about what would help the speaker most when she asked questions or made responses. We sought to make our responses affirming, or they should reflect to the speaker her own thoughts and feelings so she gained a new understanding. In thinking about each person's story and their responses, each woman could see similarities to her own narrative².

The process used was the one developed by the Dulwich Centre³⁰ and described by Michael White³¹. When the women described the impacts of child sexual abuse they talked about many emotions and feelings but most commonly shame, blame, guilt, anger, fear and love. We sought to negotiate a less structured way to define these problematic feelings so they could be explored. The aim was to focus on how such feelings shaped the woman's view of herself, which in turn played a life script that made her choose particular responses to those emotions, feelings and thoughts. The women described their feelings around the child sexual abuse as that 'package of feelings' (described in Chapter 2). We used narrative processes to explore those feelings and unpack the power dimensions and socio-cultural influences on this 'package of feelings'.

It is that package of feelings that I have to deal with that continues to rip me open. When I was two years old I was home with my brother in my arms and watching my mother being kicked down the passage. When I was 8 months pregnant with my second son, my husband was kicking me down the passage, and eight weeks ago I see my son do the same to his pregnant girlfriend. That is my 'ism'. The wounds are ripped open so easily for me.

The process involves:

1. Negotiating a 'definition' that is experience related and non-structuralist of the issue.

The issue is described and becomes separated from the woman. It is externalised and placed into the safe space of the group to explore. This exploration process slowly builds personal and group agency.

- We ask the woman to describe what's going on and give the 'package of feelings' a collective name, so she no longer describes herself as angry or ashamed, but rather she sees herself as a woman experiencing the emotion of anger.
- We make space to fully talk about the issue and do not focus on the alternative story or strengths too early as this may negate the woman's experience.

2. Mapping the effects of the externalised issue

- We ask questions that will facilitate externalising of the issue. For example, 'What effect does

that 'package of feelings' have on your relationships with your children?' Discuss how it works? What it does? What strategies do the 'package of feelings' use to influence your behaviour? What do you do to manage the package?

- What effect does that 'package of feelings' have on your thinking about yourself? If it had a voice, what would the 'package of feelings' be telling you about yourself?
- What effect does that 'package of feelings' have on your friendships, work, family, and hopes for future?
- Are there times when it has more (less) influence? Explore the history of the 'package of feelings'. How long has it been around? Then hear about alternative stories (times when the woman resisted or controlled the 'package of feelings').

3. *Evaluating the effects*

- What effects is the 'package of feelings' having on your life? Eg Would you say the 'package of feelings' is useful, not useful, or something else? Would you want more or less of that 'package of feelings' in your life? Are there aspects of the package that are more useful/helpful than others?
- When discussing these issues the worker must always privilege the client's knowledge and demonstrate personal choices that had affirming and resisting outcomes.

4. *Justification of the evaluation*

- Ask some evaluative questions such as: Why have you evaluated that 'package of feelings' as destructive? Would you say the effects of that 'package of feelings' is helpful or less helpful? Why would you say having that 'package of feelings' in your life is not OK?

5. *Using 'Look, Think, Act'*

- Once we have mapped the issue and discussed it, we consider the possibilities of actions and outcomes that will meet the needs of the woman or the group using 'Look, Think and Act'.

Using this Book

I mean, hearing myself, each fortnight, I am understanding my story more. I can pick a certain area and concentrate on that and heal it. It's not just one big messy story anymore. I can hear other people's variations, because that's important too. When you say to somebody, I really understand, do you really understand? I am learning that here.

This resource was developed as an outcome of the research process to demonstrate the practices used to facilitate self-discovery and reclamation of identity for women CSA survivors. In this book we articulate the use of the participatory action processes of 'Look, Think, Act', which facilitate the reclamation of self that promotes transition for women survivors of CSA. We explain how we used narrative structures and processes to explore and uncover power relations and social constructs within the women's stories. These processes highlight alternative self-understandings within the women by surfacing counter plot lines

and themes of courage, strength, capacity, resilience and resistance. The women can use these story lines to re-construct a continuous sense of self that has personal empowerment and agency.

It is important for the reader to recognise that this data was generated with the women and the service providers. They are the experts. We have not set out to write an authoritative text on the impacts and psychological effects of disruption and CSA on the woman's identity; nor are we trying to write a best practice guideline. As authors, we simply provide structure and process to the knowledge of participants within a framework that we know to be helpful in promoting understanding. This book is not aimed to be a theoretical work. It is written to help workers of all levels, from professionals to support workers, to comprehend what women CSA survivors say facilitates their healing. Additionally, we highlight aspects of good practice that service providers know advances the therapeutic effect of their work with women survivors. We will be delighted if you gain new or fresh insights into the needs of this client group. It is our hope that you will seek to replicate aspects of the good practices within these chapters in your therapeutic practices as you work with women CSA survivors ¹.

I think one of the things that stands out is that we can relate to each other because we have been through it. We have got to that point of being at rock bottom. We want to say to younger women who are just starting to look at their past 'It is hard for you to see how this is going to help you change the way things are, but I can assure you it really does make a difference'. It has made a huge difference to me. It is not easy. In fact it has been hard at times and it can make you feel edgy just talking about the past, but it is all worthwhile because you remove the crud and there's space to grow...

¹ The book was written with women survivors, but many of these experiences will be transferable to work with male survivors of child sexual abuse.

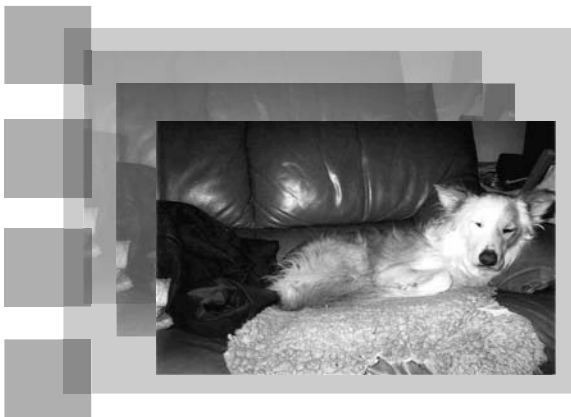
Summary

In this chapter we have articulated the aims of this research, and described the method and processes used to generate research data with women survivors of CSA, and the service providers to this client group. We introduced the 'Look, Think, Act' process as it was used to generate data collaboratively, provide guided participant reflection, and establish a narrative framework to enable women's stories to be told. This chapter provides the background for the project brief, highlighting the processes undertaken to ensure the reader of the rigour, validity and utility of the outcomes detailed in the following chapters and in the accompanying research report.



Chapter 2

Literature Review and Background Context



Introduction

There is an abundance of literature on the subject of CSA, its prevalence, impacts, interventions, and more contentious topics such as definitions, memory of trauma, and the capacity to overcome such traumatic childhood experiences. The literature review turned up thousands of articles in the databases of disciplines such as social work, psychology, psychiatry, counselling and nursing. This chapter reviews some key articles from those searches to provide a background to the research project, namely capacity building with CSA survivors who are overcoming addiction to alcohol, drugs and/or gambling which contributed to their homelessness.

The Victim

The language used in the literature to describe the person who has been sexually abused during childhood varies with descriptors such as '*victims*', '*survivors*', '*thrivers*' and '*over-comers*'. The

real 'victims' are those who have lost their life because of their CSA experiences, either through suicide, self-harm or murder. However, many women in this study saw themselves as victims at the commencement of the research. As the group work progressed they began to identify themselves as 'survivors'. None had got to the point of considering themselves as thriving, but were daring to hope that this would be the case one day. So how do we discern the qualities between each of these four descriptions?

In this study we said that the *victim* of CSA is a person who has experienced unwanted and/or uninvited sexual abuse/assault as a child ³². The victim feels unable to take personal control of her life. She may feel hopeless, confused, in pain, tired, isolated and disconnected. She struggles to make decisions and action responses that are thought-through and likely to produce life-enhancing outcomes in her life. She may be overwhelmed with emotions such as anger, fear, sadness and feelings of rage, depression, anxiety, guilt and shame. Her life feels out of her personal control. She may respond reactively to her circumstances, seeking to numb the pain of her emotions when they well up, in preference to proactive responses that meet her needs and wants. Such reactive responses can be the precursor to the woman using self-harming behaviours such as using addictive substances as one way to manage her suffering ³³.

The Survivor

The survivor is a woman who has recognised she can have a say in her own life ³⁴⁻³⁶. Rather than being impassive she consciously decides to regain some control of her life. She thinks through responses to her thoughts, feelings and emotions, and in so doing, becomes empowered to change her situation ³⁷. She has commenced experiencing her pain and owning her decisions about its management. She has started to mourn her losses and respond, making decisions about what she needs to do to get through the issues of each day. She can see opportunities and possibilities that embrace a new future that is more to her choosing. She has begun to sift through the scattered pieces of her identity and locate the pieces she wants to reclaim in her quest for her sense of self ³³. She seeks to make sense of her past, when that is possible, even if that means consciously recognising that she will never be able to understand some pieces of her life story. She has the courage and strength to make a coherent understanding of her past experiences, consciously choosing to reclaim personal power in every aspect of her self; - body, mind and spirit, and in her various roles and relationships. This inspires a hopeful future that enables the intrinsic motivation she will require to heal and eventually thrive.

The Thriver or Over-comer

The thriver is the woman who has addressed her past and made sense of her situation. Some survivors term this woman as the 'over-comer'; one who has learnt to overcome the impacts of abuse and move forward with life ³⁸. She has learned to regain her sense of self in the midst of changing life processes. These changes shift her from what she knows and understands, into territory that is new and uncharted. The thriver sees opportunities and learns the life skills she requires to respond in ways that successfully recognise that she needs to grieve endings, incorporate change, and move forward into the future of her choosing. This takes time and support when the background to the woman's life has always been chaotic and confusing. Some of the women in this study are just commencing movement into this stage.

History

The sexual abuse of children is not a new phenomenon. It has occurred throughout history ^{39, 40}. There is documented legislation enacted in 16th century England to protect male and female children under 10 years of age from rape and sodomy ⁴¹. Tomison notes that in 1672 there was a case reported by Illick in Connecticut in the United States of America where a father was found guilty and executed for sexual abuse of his daughter, however the girl was sentenced to a whipping for her participation in his crime. Intra-familial abuse has long been viewed as abhorrent, but people are unsure of how to deal with it. Perhaps because it poses a threat to patriarchal dominance and control of family structures, so it has been minimised and largely ignored. The secrecy began to be lifted and the social 'blind eye' was reversed when child battering resurfaced as a social problem during the 1960s ⁴². This correlates with the rise of the feminist movement and their focus on surfacing gendered crime. The past four decades have seen advocacy groups within the feminist movement continue to raise social awareness regarding sexual assault, rape and violence toward women and children ⁴³.

There have been arguments posited by some that having sex with children was a normal loving response and did not necessarily harm the child ^{40, 44}. Finkelhor disagreed, stating modern social behaviours were based on values such as freewill and consent ⁴⁵. Consent was not possible unless one had knowledge and authority, which children do not possess. Several cinematic movies dealing with the 'Lolita syndrome' ², add to the confused social values and mixed messages the media convey regarding, on the one hand disgust for paedophilia, and on the other hand acceptance

² The Lolita Syndrome was named after the movie 'Lolita' released in the 1990's. Such movies focus on older men falling in love and seducing women who are young enough to be their children, or grandchildren.

of the seduction and sexual objectification of younger women by older men in our society. Such incongruous values confuse the social norms around male sexual behaviour/fantasies and do little to assist the case for protection of children from the sexual predators who abuse them.

Defining Child Sexual Abuse

The literature is replete with various definitions of CSA. For the purposes of this document the participants were asked at their first individual interview to describe their sexual abuse experience. From these descriptions we deduced this working definition: *child sexual abuse is any form of sexual activity or behaviour that an adult or adolescent exerts upon a child without her/him being able to control that situation*. The women unanimously agreed the end result was a betrayal of trust and a misuse of adult power over the child.

There is no universally accepted definition of what constitutes 'sexual assault'. Definitions vary between jurisdictions, agencies and research reports throughout Australia and internationally. There are generally two types of definition. The first definition appeals to a broader, service provider definition that is suitable to support people who have experienced sexual assault. The second is a narrower, criminal offence-based definition suited to the criminal processes of specific legislation to prosecute offenders. The experienced based definition used by ABS ⁴⁶ is:

Sexual assault is unwanted behaviour of a sexual nature directed towards a person: which makes that person feel uncomfortable, distressed, frightened or threatened, or which results in harm or injury to that person; to which that person has not freely agreed or given consent, or to which that person is not capable of giving consent; in which another person uses physical, emotional, psychological or verbal force or (other) coercive behaviour against that person. Sexual assault may be located on a continuum of behaviours from sexual harassment to life-threatening rape. These behaviours may include lewdness, stalking, indecent assault, date rape, drug-assisted sexual assault, child sexual abuse, incest, exposure of a person to pornography, use of a person in pornography, and threats or attempts to sexually assault.

(<http://www.abs.gov.au/Ausstats/abs@.nsf/Lookup/FBA1483A3660DA40CA256F070079CBD2> p8)

The second is an offence based definition used by ABS ⁴⁶ :

Sexual assault is a physical assault of a sexual nature directed towards another person without their consent. The assault may range from unwanted touching to sexual penetration without consent, including attempts. Sexual penetration involves: the introduction, to any extent, of a person's penis into the vagina, anus or mouth of another person; or the

introduction, to any extent, of another part of a person's body or an object into the vagina or anus of another person. Consent requires 'free agreement' and a person cannot be said to freely agree where the person: is fearful for themselves or for someone else; has been threatened; is mistaken about the identity of the person or the nature of the sexual act; wrongly believes that the act is for medical purposes; is incapable of consenting because of the influence of alcohol or other drug(s); or is legally deemed incapable of giving consent because of youth, temporary or permanent incapacity, or where there is a familial relationship or other relationship of trust.

(<http://www.abs.gov.au/Ausstats/abs@.nsf/Lookup/FBA1483A3660DA40CA256F070079CBD2> p9)

One key issue within these definitions is the lack of consent:

A physical assault of a sexual nature, directed toward another person where that person: does not give consent; or gives consent as a result of intimidation or fraud; or is legally deemed incapable of giving consent because of youth or temporary/permanent incapacity.

<http://www.abs.gov.au/Ausstats/abs@.nsf/Lookup/6A5AC4F1840B41B9CA256EA00079BD78> p.40)

(NB. The same definition is present in the ABS 2003 report ⁴⁷ but is absent from the 2004 report glossary ⁴⁸.)

Definitions are notoriously problematic as there are controversies and anomalies in Australian law around each term, such as the legal age of a child, what the term sexual means, and what constitutes abuse. Haugaard notes three obstacles that hamper the ability to find an acceptable, explicit definition of CSA ⁴⁹. These obstacles include the various *professional contexts* in which the words are used and the differing mandates of each of these contexts. For example, legal professionals prefer an exact and narrower definition, whereas counsellors and social workers prefer a broader more inclusive definition. The second impediment is that most of the characteristics that qualify whether a child was sexually abused present along a *continuum of characteristics*, where the demarcation occurs may be disputable. For example a parent bathing their healthy two year old is acceptable, but a parent bathing their healthy 14 year old would most likely not be socially acceptable.

The third obstruction is the *context in which the behaviour occurs*, which may sway the decision about the nature of the behaviour as abusive, or not. The women readily agreed that an adult having intercourse with an 8 year old was CSA, but a parent walking around naked in their home in front of an 8 year old was unlikely to be. A 15 year old sleeping in the parent's bed may be, but a four year old sleeping in the same bed as the parent was most likely not. Defining assault/abuse involves notions of intention of the behaviour, as it relates to generally accepted social values and practices,

and the issue of truly informed consent ^{45, 49}. The child's consent to sexual activity seems to be a moot point because the power and control always lie with the adult perpetrator who can readily coerce the child into sexual compliance ^{50, 51}. The women's definition seems to agree with an earlier one by Tower ⁴⁰ who said CSA involves adult sexual gratification derived from activities that ranged from exposing the child to sexually explicit materials or behaviours, taking images of the child for pornographic purposes, touching, fondling and/or masturbation, oral, anal or vaginal penetration of the child. National data set statisticians lament that:

There are no reliable measures of the prevalence of child abuse and neglect in Australia, mainly due to the difficulties in both defining and measuring abuse and neglect. Prevalence rates can vary considerably depending on the definitions used. The only available data relate to situations where children have come to the attention of the child protection authorities in each jurisdiction. These administrative statistics represent only a proportion of all abuse and neglect cases that occur within the community. In Australia, child protection is the responsibility of the state and territory governments ⁵².

(<http://www.aihw.gov.au/publications/index.cfm/title/10127> p56)

The definitions spelt out in the various State child protection legislation take up six pages of an appendix in the most recent child protection data set from 'Australian Institute of Health and Welfare' ⁵³. Earlier AIHW definitions say sexual abuse is any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards ⁵⁴. While this helps to clarify behaviours it leaves room for interpretation, which may leave children in some cultural and ethnic groups at great risk. Sexual exploitation or activity that a child is compelled to observe, or be involved in (Eg pornographic videos) is also a form of CSA. Thus the 'Centre Against Child Sexual Assault' (<http://www.casa.org.au/index.php/1>) has defined CSA as 'any unwanted sexual behaviour that makes a person feel fearful, uncomfortable or threatened, including any sexual activity the person has not freely agreed to'.

The classification of CSA in the literature pertaining to Post Traumatic Stress Disorder, indicates that the event is often traumatic because the child experiences, witnesses or is confronted with events that involve actual or perceived serious harm, death or a threat to the physical integrity of self or others ⁵⁵. Such classification takes into account harm, but not the intent of the perpetrator, which must be considered if the behaviours are to be seen as assault or abuse. The 'Central Agencies Sexual Abuse Treatment' handbook in Canada disagrees noting,

Any form of direct or indirect sexual contact between a child and an adult is abusive since it is motivated purely by adult needs and involves a child who, by virtue of her/his age and position in life, is unable to give consent. Sexual activity between children constitutes sexual abuse when it is between siblings or when it is clear, by difference in developmental levels, coercion

and/or lack of mutuality, that one child is taking advantage of another. (Child Sexual Abuse Protocol, 3rd Edition, 1995:1 quoted by Colton and Grossman ¹ <http://www.casat.on.ca/handindx.htm>)

It was certainly the case that most of the women in our research group who had experienced incest and/or intra-familial sexual abuse were often also abused physically and more particularly, emotionally, a finding that supports claims made by Schacter ⁵⁶.

The most recent definition laid down in the current 'Children in State Care: Commission of Inquiry in South Australia' defines sexual abuse as:

Conduct which would, if proven, constitute a sexual offence, where a sexual offence is defined within the meaning of section 4 of the 'Evidence Act 1929' ⁵⁷. A sexual offence 'means, rape, indecent assault, any offence involving unlawful sexual intercourse or an act of gross indecency, incest, any offence involving sexual exploitation or abuse of a child, or abuse of a child as an object of prurient interest, or any attempt to commit, or assault with intent to commit, any of these offences (<http://www.statecareinquiry.sa.gov.au/Reports.htm> pp 5-6) ⁵⁷.

The Common Story

The storied accounts generated with the women have diverse individual detail, but they present a readily identifiable 'common story' which the women want to offer, using their own words (in quotation marks), to alert professionals to the likelihood of past CSA and the need for sensitive intervention and appropriate referral.

We were told throughout our lives that we were 'useless', 'good for nothing' and 'deserving of everything we got'. This was reinforced by 'betrayal' from our family and 'manipulation' from the perpetrator/s who 'dominated' us from their position of power and trust, making us feel 'powerless', 'worthless', 'ashamed', 'guilty' and 'to blame somehow'. We were 'used' and treated as 'objects' or 'meat'. When other children were developing 'the building blocks for a strong identity' and understanding that they were unique and worthwhile, 'able and OK'. We were 'stuck' in a world that taught us 'we would never amount to anything'. But worse, we still carry the burden of 'shame' and 'guilt', 'confusion' and 'sadness' which continually diminishes our 'self-worth' and 'shatters our identity'.

We spent our childhood maintaining a shroud of 'silence and secrecy' around our perverse experiences of child sexual abuse. We coped by 'suppressing memories', 'learning to forget', 'disengaging', disassociating', 'isolating ourselves emotionally and relationally', 'trying to please everyone', 'trying to adapt' and accommodate our 'weird' situation', because there was 'no escape anyway'. This allowed us to survive our childhood. But as we became teenagers we came 'unstuck'. We knew we 'didn't fit in'. So we 'numbed our rotten feelings' by using alcohol, drugs and/or gambling.

For some of us self-harm and re-victimisation continued. Weak 'boundaries' made us 'an easy target' for 'predatory people', increasing our 'hopelessness and sadness'. We no longer trusted easily because 'everyone seemed to want something from us', so we chose to become 'disconnected' to protect ourselves from further 'hurt'. We had 'few dreams or hopes for the future' using addictions to 'escape', 'cope' and even 'survive'. We recognise these were 'toxic life patterns'.

When we encounter health professionals we would like them to help us with 'sensitivity', 'understanding', 'respect' and 'support', so we can 'heal and grow' toward the future that was 'taken from us during childhood'. We were 'victims', but we have become 'survivors', and with help we are daring to hope and believe we will eventually 'thrive'.

Prevalence of Child Sexual Abuse

The epidemiological findings becoming available indicate that CSA occurs across most cultures and in most places⁵⁸. Studies undertaken by the 'National Crime Prevention Taskforce' initiated by the Federal Attorney General's Department⁵⁹, about the experiences and attitudes of Australian youth towards family violence say they perceive sexual assault as the most disturbing and relevant issue to young people today. Not a surprising finding given sexual assaults increased by an average 5% each year between 1995 and 2002⁶⁰. In 2002, 80% of sexual assault victims were female, but the number of male victims of sexual assault increased by 17%. Interestingly, sexual assault numbers peaked during the summer months of January to March and are lowest in the winter months, April to July.

It is challenging to create a clear picture of the prevalence of CSA, because of varying definitions, under-reporting and sampling limitations. The official statistics note that current approximates are an underestimation of the actual prevalence of CSA. The estimates of the prevalence of CSA in Australia vary between 8-60% (women) 3-29% (men) when definitions include non-contact abuse such as

exposure to pornography, photography, watching, exposing, and flashing⁶¹⁻⁶³. The figures decrease with narrower criteria of sexual penetration, intercourse (including digital, oral, vaginal and anal) with prevalence rates of 1.3%-28.7% (women) and 1.1%-14.1% (men)^{64, 65}. The 1996 Australian Bureau of Statistics estimated 38% of adult females had experienced one or more incidents of physical or sexual violence in their lives⁶⁶. A study by Fleming revealed 35% of Australian women had at least one incident of unwanted sexual contact with an adult before the age of 18 years⁶³. Such figures would support Australian estimates that 1 in 4 girls and 1 in 12 boys have been sexually violated⁶⁷.

Prevalence statistics from South Australia are tricky to authenticate due to notoriously low reporting rates, preventing accurate assessments. Justice Mullighan (2005:20) notes 'it is safe to accept that at least one child in every five is sexually abused'^{57, 62}. Layton⁶⁸ noted that in South Australia during 2001/2002 there were 18 500 notifications of child abuse reported under the mandatory reporting system. Of these, sexual abuse notifications made up 13% or 2308 (involving 2000 children) of the total notifications. Of these 530 were referred to Police and 500 to the South Australian statutory welfare agency 'Family and Youth Services' (FAYS). Of the cases investigated by FAYS, 175 (involving 166 children) were confirmed as abuse. Police crimes against children for 2000-2001 involved 4 500 offences against children of which 952 were sex offences. From this number 569 cases were cleared in that year, and in 27.7% (n=158) of cases, the victim requested no further action. Of the 569 cleared cases in relation to sex offenders for the year 2000-2001, a guilty finding was recorded for a total of 96 offenders, which is a conviction rate of approximately 17% for all cleared cases.

The 'Office of the Status of Women' commissioned a nationwide survey titled the *Women's Safety Survey*⁶⁶ which is the most recent comprehensive large scale survey undertaken within Australia aimed at identifying the extent of violence perpetrated against women. The survey highlights the serious under reporting of sexual assault and the scandalously low rates of conviction for sexual assault crimes. In Victoria 1996/97 at about the same time that the women's safety survey was undertaken, only 5 per cent of sexual assaults that were reported to the police resulted in a conviction⁶⁹. The same comment was made by Kerr (2003:7)⁷⁰, who termed the phenomenon of attrition between reporting to 'Family and Youth Services' (now 'Child and Youth and Family Services') and conviction in the courts as "The Oz Twister". He noted that the figures for the period between 1998 to 2000 saw more than 1000 substantiated reports made to FAYS that resulted in only 60 convictions, a meagre 6%. Kerr⁷⁰ notes the ability to track the statistical evidence of child protection departmental reports, substantiated police reports, and prosecutions from court administration authorities, is not as simple and transparent as one would hope. Bear in mind these are 'substantiated' cases and do not consider those cases that go unreported. It is reasonable to say that children are not being afforded a fair hearing in court, nor are they obtaining legal redress. Even when the case does make it to court, the adversarial system of justice conspires to create such

a state of confusion and anxiety in the child that contributes to a sense of ongoing victimisation, alienation and rejection. This issue is expanded in depth in recent work by Taylor ^{71, 72}.

The most recent child protection data from Australia for the period 2003-04, indicates the number of child protection notifications doubled from 107 134 in 1999-2000 to 219 384 in 2003-2004. Some of these increases are due to changes in child protection policies and practices, which are a positive indicator that Governments are taking the issue of child protection more seriously. The rates of substantiations increased in all jurisdictions, which suggest a response to reporting is having effect.

The number of substantiated reports of child abuse (predominantly for neglect) of Indigenous children is disproportionately higher (8 times higher in South Australia) than in the non-Indigenous population, with the highest substantiations occurring in Victoria and Western Australia ⁵³. However, there are proportionately less substantiations of sexual assault among Indigenous children by child protection departments, than for non-Indigenous children. Substantiated CSA was verified in 9% of Indigenous children and approximately 17% of in non-Indigenous children. However, these figures have been disputed as underestimating the actual levels of CSA amongst Indigenous Australians ⁷³. The rate of Indigenous children in out-of-home care is nearly seven times the rate of other children in out-of-home care ⁵³.

The Gordon Report ⁷³ rates CSA of Indigenous children as significantly greater than in non-Indigenous children because of the reluctance of reporting due to fear of racism, shame, police reaction, difficulty communicating, lack of trust in white justice, absence of persons to report to, fear of reprisal from the perpetrator, and protection of the perpetrator. This is especially true in northern Australia where women may be held responsible, under Indigenous tribal law, for the death of the perpetrator, if they die in custody ⁷⁴. Failure to respond to Indigenous assaults is most likely due to the normalisation of violent behaviour in Indigenous communities, past inaction of authorities, authorities who are fearful of damaging their ability to live and function safely in the community, or authorities that are overwhelmed by the size, complexity and number of incidents in the community ⁷⁴⁻⁷⁶. Stanley and colleagues ⁷⁴ note that pathologising the problem of CSA does not take into account the more holistic approach required to address the broader issues of trauma, deprivation, racism, violence, lost cultural identity, substance abuse, and the unmet basic needs of women and children, in Indigenous communities. CSA must be understood within that context if it is to be managed effectively ⁷⁷.

The Impacts of Child Sexual Abuse

Being sexually abused during childhood often has short and long term impacts that effect the health and wellbeing of the individual ⁷⁸⁻⁸¹. Each survivor has her own individual and personal experience of the trauma, hence each woman will respond according to her own background and past experiences, and will call upon her unique combination of strength and skills in order to survive ⁸². The heterogeneity of the sample of CSA victims regarding the severity, frequency and type of sexual assault experienced, coupled with the variations in definitions of abuse, social contexts, relationships with the perpetrator and ongoing support for the child, make it difficult to be exact about what are the likely short and long-term consequences of CSA ⁴⁹.

What we do know is that the impact of CSA pervades every aspect of the survivor's life ⁸³. CSA is perhaps best viewed as a risk factor for a wide range of profound life issues, including diminished self-esteem, relational difficulty, problems with sexuality and intimacy, alcohol and drug misuse/abuse and decreased life chances due to lower socioeconomic status ⁸⁴⁻⁸⁶. In most cases, the primary harm caused by CSA is to the child's developing ability to trust, relate, agency and sexuality ⁸⁴. There are indications that trauma during childhood may have neurobiological effects, which place the child at risk of long term psychological, emotional and behavioural problems ^{87,88}. There is a well documented increased risk of alcohol and substance abuse, and established links between CSA and mental illness ^{65, 89-97}. Conditions that should alert professionals interacting with the child to think of CSA as a possible contributing factor to health problems include, but are not limited to; depression; addiction; anxiety and panic disorders; personality, dissociative identity, compulsive and eating disorders; self-harm; sexual dysfunction; and stress related health problems such as, headaches, back pain, abdominal problems such as irritable bowel, chronic pain etc ^{65, 90, 91, 98-105}. However, abuse is not a destiny and damage if not reparable, may be ameliorated with appropriate care. Hence the potential for capacity building with women is part of the role of every caring health professional ¹⁰⁶.

I couldn't get close to anybody, emotionally close. It was like my body would just switch off and I'd just be there, but you know I might as well have been doing something else. Now it's starting to feel like my body's coming back to earth and all the emotions and everything's coming together in a more manageable way.

A national co morbidity survey conducted by Ullman and Brecklin ¹⁰⁷ examined the correlation of past-year chronic medical conditions, and lifetime contact with health care professionals for mental health and substance abuse issues in 627 women with histories of sexual victimization (childhood, adulthood, or in both life phases). They found, as have other researchers, that Post Traumatic Stress Disorder (PTSD) and stressful life events are associated with greater odds of chronic medical conditions in women who have been sexually assaulted in childhood ^{94, 108}. They found women who

were child victims sought help for stressful life events, but were less able to seek help for traumatic life events as adults. Alcohol dependence symptoms and PTSD were each associated with greater odds of lifetime health care professional contact, as was depression.

A study was undertaken with a group of patients who reported histories of childhood sexual trauma but had not experienced intense disruption as adults. However, when this group sustained a temporary brain injury in adulthood they experienced a re-emergence of disruptive thinking due to intrusive and vivid memories of symptoms related to their past abuse experiences. The symptoms included those commonly displayed in clients with PTSD, namely flashbacks, behavioural and affective disturbances, nightmares and hyper-vigilance. These women were treated with five therapy sessions that focused on narrative therapy relating to the abuse episodes, learning relaxation techniques and guided imagery to help the women control flashbacks ('placing the scene in a book and closing the cover'). The authors state these therapies change serotonin and select catecholamine activity which they state diminishes the likelihood of flashbacks ¹⁰⁹.

Table 2.1
Possible Impacts of Child Sexual Abuse

<p>Physical conditions</p> <ul style="list-style-type: none"> • Abdominal pain 'tummy ache' • Generalised body aches and pains • Headaches and migraines • Stress symptoms 'tight jaw, hard to swallow, sweaty palms, shaking, tight in the chest, etc' • Nausea and vomiting • Diarrhoea • Constipation • Can't control urine or faeces • Injuries or irritations of vagina and / or bottom • Cystitis - urinary infections • Bed wetting • Vaginal infections • Sexually transmitted diseases • Mouth ulcers • Heartburn and indigestion • Stomach and bowel ulcers • Skin conditions - rashes & eczema • Asthma • Pregnancy • Abnormally high pain tolerance • High blood pressure • Muscle tension, tight & tingling in shoulders, neck and back • General pain and stiffness • Psychosomatic illness & pain (where there is no physical cause) 	<p>Emotions and Feelings</p> <ul style="list-style-type: none"> • Fear (Eg dark, certain places, people, dentists, doctors, situations) • Anger - issues with recognition, use, expression, control, misdirection • Guilt • Shame • Self-Blame • Hurt > emotional pain • Sadness > crying and sorrowful • Anxiety, 'nervous', panic, agitated • Overwhelmed > feeling helpless • Confusion for no apparent reason • Frustration > bitterness • Hate (particularly self-hate of body) • Spite > desire for revenge • Withdrawn, quiet and secretive • Emotionally numb • Wild mood swings • Underestimate their ability • Studying and work - may be extreme, drops out, changes, or overachieves
--	--

<p>Physical effects</p> <ul style="list-style-type: none"> • Difficulty sleeping • Dreams and nightmares • Flashbacks • Weight issues (under or over) • Difficulty concentrating • Deep grief and sadness • Chronic tiredness and fatigue • Deep reaction to an unexplained situation Eg a smell, place, person • Addictions – alcohol, drugs, gambling, sex, work • Outbursts of rage and anger • Violent behaviour • High tolerance of pain • Ability to numb body sensations • Hyper-vigilant, hypersensitive <p>Relational Issues</p> <ul style="list-style-type: none"> • Disrupted attachment and development stages • Feel ‘different’ > isolation • Partner relationship difficulties - insecurity, sexual, trust, violence • Boundaries in relationships with intimate partner, children, etc • Cannot assert rights readily • Confusion re sexual identity especially if abused by someone of same gender • Disruption > move house, jobs and schools. Often ‘on the run’ 	<p>Psychological problems and Psychiatric ‘diagnoses’</p> <ul style="list-style-type: none"> • Trust issues - too much, can’t trust anyone, mistrust of self • Uncertain of identity ‘Who am I?’ • Obsession: thoughts are difficult to control • Compulsive: the rituals we need to feel safe become difficult to control • Perfectionist ‘nothing quite good enough’ • Fears and phobias Eg fear of dark; medical, gynae & dental procedures • Depression - crying, deep sadness • Anxiety disorders • Post Traumatic Stress • Panic attacks - especially common • Self-injury and suicidal thoughts/attempts • Psychosis • Dissociation ‘spacing out’, ‘numbing’ not present in the moment, memory gaps • Multiple Personality (dissociative identity) • Eating disorder: anorexia, bulimia, bingeing • Extreme behaviours Eg drop out of jobs easily, or always push self to achieve more • Reactions to triggers - sensory, places, words, furniture, people, professions. <p>Spiritual issues</p> <ul style="list-style-type: none"> • Feeling empty, inside ‘a dark hole’ • Loss of meaning and purpose in life • Loss of will to live • Hopeless ‘no way forward’ • Loss of faith in God, ‘abandoned by God’ • Loss of trust in religious leaders
--	--

There are factors that mediate the effects of the assault/abuse and these include the type of abuse/ assault that occurred, the age and developmental stage the child was when the abuse occurred, the duration, frequency and level of force of the abuse. Additionally, the personal and social capacity and the interpersonal resources of the survivor and her relationship/s with family, partner, other people and the perpetrator, will all influence coping ability. Finally, how the disclosure of the abuse was received by significant others, and the meaning they and the survivor give to the experience, also mediate the impacts ¹¹⁰.

Points about the use of CSA ‘indicators’ to assist the disclosure processes

- If services use indicators, be clear as to how the indicators should be applied. Be flexible in the approaches used because many of these signs can also be caused by other traumatising circumstances.
- Avoid using them to ‘label’ or as a check box assessment of the client.

- Use them to raise the awareness of workers (especially people who are new to working with CSA survivors) so the worker knows what to observe and listen for.
- It is important to focus on what each of these indicators means to the woman who displays them. This should guide your assessment.
- If you are going to ask questions about CSA using these indicators then you are ethically bound to offer some assistance or referral, and you may not have the resources to do this.
- Remember to pay attention to your language, because some women will not talk about 'abuse' or 'assault' because they do not perceive their experiences to be 'abuse'.

It is important to highlight that having a checklist of the effects of CSA can aid and abet feelings of impotence in the face of past CSA for survivors. It can lead to professionals typecasting survivors into a destiny of illness and suffering, rather than encouraging possibilities for wellness, overcoming, flourishing and thriving. The aim of lists such as Table 2.1 and those in the popular book 'The Courage to Heal' ³⁶ is to identify people who may have a possible history of CSA on the basis of frequently cited indicators demonstrated and documented by survivors ^{99, 111}. Some authors suggest that the indicators may be caused by other militating social and life factors, stating that to hypothesise that these indicators are caused by CSA, could be risky ^{80, 112, 113}. The list of indicators has been debated by other researchers ¹¹⁴⁻¹¹⁶ but suffice to say with such variations in the severity of impacts and consequences of CSA, one needs to be sure that the indicators are used with great care ^{99, 111, 112}. The list in Table 2.1 is provided so that if a client presents displaying several of these indicators, you will have sufficient knowledge and awareness to ask the right assessment questions so the person has an opportunity to speak out if she/he feels safe and able to do so.

Using Narrative Therapy to Surface Somatised Memories

There is evidence that traumatic memory can be somatised in the body, encoded and remembered by the body as part of the unspoken non-declarative memory that is independent of the more usual language-based memory. Current stress may recall traumatic memories that are experienced as somatic or body memory ^{100, 117}. The survivor's body refuses to allow her to ignore her past. Some scientists say traumatic experiences can be somatised into memory that is relived via nightmares, flashbacks, startle responses, dissociative behaviours, frequent illness and pain. Consequently, frequent internal and external stimuli result in stress responses in the survivor's body that create the long-term chemical changes that can lead to disease. The body reacts with either a 'fight/ flight' or a 'freeze/numb' response. Rothschild notes the 'freeze/numb' response is more common in women and children who feel powerless and can lead to effects where the child/adult is 'vague', 'absent',

'accident prone', 'apathetic', not caring for herself adequately, misusing alcohol/drugs, or involved in other addictive behaviours ¹¹⁸. The survivor is often confused by the intense emotions that are triggered and perplexed about how to moderate them. To cope with the confusion regarding the physical sensations of past trauma, people must be helped to keep body and mind together, and stay present in their bodies, experiencing the bodily sensations as part of healing ¹¹⁸.

Giving words to such somatic disturbances helps the woman make sense of them, so she comprehends their meaning, extracts their message, and resolves their impact. In the group work the language and metaphors the women use to describe their experience allow them to externalise the problem/issue/sensation so they no longer need to experience it in its somatised or internalised form. The use of metaphor alleviates the need to re-experience abuse cognitively ¹¹⁹. The stories the perpetrator/s dictated to the women are reframed. These stories, which have been replayed over and over for years, are so deeply internalised that the process of naming and understanding will usually take time. However understanding grows with new meaning being ascribed to situations that over time, lead to liberating insights and empowering actions.

In psychological theory the notion of 'transference' refers to the relocation of feelings and insights about one's past situation, to experiences that are in the present. Transference may be positive and invoke happy feelings, or even neutral, but it may also resurface unhelpful feelings that interfere with healthy functioning, adaptation and transition. Schacter provides the example of the CSA survivor, who was criticised, put down and abused by a parent and comes to visit a health professional (or an authority figure). This person passes comments that the survivor perceives as criticising her, yet criticism is not the professional's intention ⁵⁶. Understanding transference can help professionals to avoid taking client responses personally. It also ensures that you have a heightened awareness of what you say, in the knowledge that CSA survivors may have difficulties with transference.

Similarly, counter-transference can occur when the health professional shifts her/his feelings and observations from past life or client situations to the relationship with the current client, or allows the client's transference response to provoke a non-

therapeutic response. Counter-transference can present as, needing to be liked by your clients; emotional over-involvement with the client; needing to be admired by colleagues; needing to have your viewpoint expressed and approved on any topic etc. The women in this study provided numerous examples of professionals that the women said 'had not dealt with their own issues'. Transference and counter-transference responses are a common human reaction. The reflective practitioner must take time to work through such situations ethically, so as not to hinder the therapeutic capacity of the intervention. Such adverse interactions can develop client resistance to accessing professional help to facilitate the healing process ⁵⁶.

She (the counsellor) told me I don't love myself enough and I was put out. She was rude and I didn't want to go back there. I felt like she was picking on me.

CSA and Homelessness

I ran away as soon as I was 12. I got brought back and ran away again and again. Then I was gang raped while I was on the streets. I was 13. I have been on and off the streets ever since. What is the right thing to do? What is the best thing? Where can I go now? Do I need to be lectured, or do I want the freedom of the streets? Do I want to go back to checking my back all the time on the streets? You know, it's a hard one really 'cause I don't wanna go back, but I know that if I stay on the streets, I'll get sick and probably won't get as well as if I sat in X ...I know how it goes... 'Ohhh the marijuana won't hurt' and I'll start smoking again and then I'll think 'Oh, a couple of ... wouldn't hurt either'. It will spiral down, I know...

Sexual abuse has been found to be a key factor in the cause and continuation of youth homelessness with between 50-70% of young people within Supported Accommodation Assistance Program (SAAP) services having experienced sexual assault. Very few young homeless people who access SAAP services are provided with counselling support pertaining to sexual abuse ¹²⁰.

CSA is a major contributing factor to youth and adults becoming homeless and experiencing family and intimate partner violence. There is also considerable research that indicates it is linked to misuse/abuse of alcohol, gambling and drugs; mental illness; self-harm and difficulty managing anger. These all contribute to interpersonal conflict, which is a key catalyst for homelessness ⁹².

¹²¹⁻¹²⁴.

CSA and the Legal System in Australia

The ongoing increase in homelessness highlights our societies inability to take a strong stand about the criminal nature of violence perpetrated against women and children ^{76, 125}. It was beyond the scope of this project to explore the wider legal literature but there appears to be an appalling lack of convictions for sexual assault in Australia's judicial system, making the system appear impotent at providing legal redress to victims of sexual assault and violence ^{58, 70-72, 125}.

In a survey undertaken in Queensland, Western Australia and New South Wales in more than half the children interviewed report further abuse based on their adverse experience within the judicial system. In Queensland 39% of child complainants said they would not report, and 17% said they were not sure, and in New South Wales 56% said they would not report, and 11% were not sure ⁵⁸. In Western Australia 17% said they would not report and 19% were not sure. Across all jurisdictions, two-thirds of the children who said they would not report again had obtained conviction for the offending perpetrator. Such reluctance of children to re-enter the criminal justice system is a critical finding that should concern everyone, because the statistics demonstrate that these children are more likely

to experience ongoing violence in adulthood. Their concern about their adverse experiences in the justice system during childhood may prevent them from reporting any future incident ^{94, 126-128}.

There is little doubt that the adversarial nature of the judicial system has detrimental effects on the child ⁷¹. Cross-examination is central to such a system. If the child is deconstructed at the same time as the case is broken, it is almost as if this occurrence is considered to be unfortunate collateral damage of our legal process. One Queensland Defence Lawyer stated:

The Crown doesn't care about the child. The police don't care about the child. And I don't care about the child. You see the trial is not about the child. It simply makes the child a witness... You've got to get around this idea that the criminal justice system is about the child, it shouldn't be about the child, and hopefully will never be about the child ⁵⁸.

There are claims made that the purpose of cross-examination has little to do with locating truth, but is more about manipulating the witness with techniques designed to harm the effectiveness of the child's testimony by confusing them and rendering their complainant voice mute. The techniques used include ridicule; character attack - depicting the child as 'the nut, or the slut' ⁷⁶; layered and repetitive questioning to create confusion; closed questioning, so only yes/no answers can be given; frequent interruption, so the child loses their train of thought ^{71, 72, 129}. The insinuation from defence lawyers is that the child is lying, unable to discern the truth, remember accurately, that they 'asked for it', 'enjoyed it', or somehow 'wanted' the assault ⁷²! Given the reluctance for change from within the legal system, it may be public pressure and assertiveness from professionals concerned with the rights and protection of children who need to step up their advocacy and lobby Governments for changes to the laws and improvements to processes within that system. Surely such changes must commence when Governments realise the economic costs of CSA and the benefits of child protection ^{130, 131}.

Whatever the case, children are not equal partners in the legal forum. The balance usually tips in favour of the adult and rather than an accurate representation of guilt and innocence. The report by Layton has recommended changes to redress the imbalance in the justice system and prevent further revictimisation of children. She suggests new models for taking of evidence from children in relation to criminal trials, improving interviewing processes for child witnesses, allowing opportunities to view video evidence, flexible approaches to competency testing for children, establishing court-based witness support for children, and more diversionary programs for sex offenders, as well as a state-wide offender monitoring and screening program ⁶⁸. No doubt when the final report of the 'Commission of Inquiry into Children in State Care' being conducted in South Australia by Justice Mullighan is presented, there will be many more suggested reforms ⁵⁷. What remains to be seen is whether Governments of all persuasions have the political will to make the necessary legislative

changes to enact recommendations. As Kerr (2003:10) says 'the scales of justice are not simply weighing the guilt or innocence of an accused. They are also the crucibles in which our community measures its capacity to be just and fair to all its members - including our children' ⁷⁰.

What Happened Within the Survivor's Family?

My Mum used to say to me, "You've always been weird. You've always been strange." The strangeness came from me seeing the dislike in her face and reacting to it by putting on another identity. You do it to save yourself from being hurt, you know. I've had some severe beatings and just stood up and said, "Yeah, come on, go again!" Even though it was killing me inside and I was hurting so much and crying within. It's the face you put on to pretend that it doesn't matter, so you can survive emotionally. I think inside all of us there's a little grain of hope that always wants to keep trying to save the relationship all the time. It's like a little spark that keeps waiting and hoping for a connection.

The literature on CSA notes that the family life of CSA survivors is often interwoven with other forms of abuse, such as emotional abuse and physical violence. Many participants in this study experienced assaults within their childhood families. These were usually not isolated events, but were endured over many years. This finding is echoed in a study by the State Government of Victoria ¹³². In most cases the women were sexually abused before they became adolescents, with most recalling their earliest memories of sexual abuse between the ages of 5 and 8 years. The backgrounds of the participants varied across rural, remote and metropolitan settings and all social strata of the society were represented, including professional, paraprofessional and working class families. There was an over representation of perpetrators who were in positions of legally sanctioned authority. Often women reported there were compounding social issues within the childhood family that included fragmentation of the family through divorce, family violence, alcohol and drug addictions, and mental illness.

In most cases the family presented to the outside world as "normal" but the experiences of the children within those units was anything but normal, or healthy ¹³³. Family relationships were characterised by intimidation, fear, shame, blame, secrecy and isolation, to avoid exposing the family to scrutiny. They were silenced by fear of what would happen if they divulged the family secret. This was usually done using threats from the perpetrator who made excuses to justify his/her behaviour using blame, intimidation and fear tactics to maintain the child's silence. It is difficult for the child to shake the belief that they were not to blame for the abuse, or that they did not contribute to it in any way, because this was the message conveyed to them by the perpetrator and sometimes other family members. The child learns not to trust adults due to the complete and repetitive breaches of trust

that they experienced. This makes them sceptical about being heard and understood, and afraid that they will not be believed, hence they prefer not to tell.

Perpetrators make excuses to avoid taking responsibility for their abusive actions and most commonly the child is blamed for somehow provoking, or enjoying the abuse. Unfortunately when children do tell and the offending perpetrator denies their actions, it is often the perpetrator who is believed rather than the child. It is confronting to acknowledge that such abhorrent and repugnant behaviours are occurring to a child, making it threatening to confront the perpetrating adult. If the adult that the child discloses to does not take action it may convey to the child that they are not worthwhile, or that they must be to blame. It reinforces their mistrust of adults and readily drives them into deeper silence, isolation, internalised anger, which quickly leads to despair and possibly to mental illness ⁹².

I was very quiet. I did a lot of reading, that's why I was always ahead in reading, but behind in maths. It was my escape, my link to the outside world. I didn't get along with other kids, because I was very shy. I was at home and often sick. I got teased because my uniform was different to everyone else's, but my parents never cared. No one was allowed to come to my place, not that I would have invited them anyway. I never went to anyone's house either. I didn't trust anyone because it wasn't safe to do that. I did a few times and they'd pretend to be friends and then throw my lunch around, or my home work and my books. They'd just torment me... I got used to it... I was everyone's scapegoat at home and at school. I was always different, so I got tormented. I learnt to shut up so I was noticed less. I stopped speaking, that meant less trouble for me.

Survivors suggest that while children need to be educated about stranger danger, most abuse occurs with a person the child knows, so the child also needs to be taught to say no to uninvited and unwanted behaviours. This is not as simple as it sounds because children find it almost impossible to have a voice that their perpetrator/s will listen to.

Memories and Flashbacks

Many adult CSA survivors repress memories of the events in order to live and function in the everyday. They actively avoid discussion of their experiences because they involve disgusting, humiliating and embarrassing details that are painful to recall ¹³⁴. Disclosure is possible if professionals ask the right questions in an atmosphere of compassion, safety and holistic caring ¹³⁵⁻¹³⁷.

There has been much debate concerning the possibility that people forget traumatic experiences, only to remember them years, even decades later, and how reliable such recovered memories are ^{138, 139}. Some authors suggest recovered memories of CSA are unintentionally placed in the minds of clients by psychotherapy ^{140, 141}, but others say the memories are likely to be accurate ^{142, 143}. A study by Williams provides support for the notion that childhood traumas may not be routinely displaced from conscious awareness and may be reliably recovered at a later time ¹⁴⁴.

CSA survivors say flashbacks and memories may be triggered by sensory cues and experiences that foreground the emotions and feelings that were present during the abuse, or force the survivor to relive physical sensations and mental thoughts that were present in the abuse circumstances ^{117, 144, 145}.

It wasn't only my dad that abused me, I was sexually abused by a neighbour, and a grandfather who was an ex-detective, and there was a woman involved. It was pretty horrific. I often woke up and my parents wouldn't be there. One night I woke up and I had nearly drowned in my own vomit. I had vomited in my sleep, and I woke up crying. I went straight to their bedroom and they weren't there. I went through the whole house looking for my mum and dad, and they weren't there. They were out partying and drinking. I felt so let down, because they weren't there. I went to the next door neighbour's house and there I was sexually abused again...

Disclosure

Elie Wiesel a Holocaust Survivor is quoted as saying 'What hurts the victim most is not the cruelty of the oppressor, but the silence of the bystander'. This is true also for the victim of CSA who discloses and is met with silence, or tells and is not believed, or tells and sees no further supportive action as a result of disclosing.

There are many different reasons to explain why children do not disclose immediately after the first abuse, however it is common ^{133, 146}. Not everyone who has disclosed has found it helpful ¹⁴⁷. It is

T.A.L.K.

T = Take charge and tell someone

A = Access those who can help

L = Listen to others and learn from their experiences

K = Knowledge gained leads to prevention ¹

extremely difficult to do because often the child is not aware of exactly what is going on. There is much written as to why disclosure is so difficult, but the dominant themes include fear of the perpetrator's threats, punishment, rejection, negative reactions, being treated differently, upsetting parents, breaking up the family, being taken away from the family ^{137, 148, 149}. The child experiences confusion because she cannot understand

what or why this is happening, she cannot find the words to describe what happened, the mixed emotions of love for the perpetrator and hate for what they have done. The child struggles to make sense of why someone who she loves and should trust can do such a thing. She may be confused because some aspects of the abuse felt enjoyable, exciting and sensually stimulating ¹⁵⁰. She often feels guilt because she has been blamed for the sexual abuse, she may even think she 'asked for it', 'invited it' or 'deserved it'. She may be experiencing hurt, embarrassment and shame over what happened, so it seems easier to remain silent about the incident ¹.

My experience was so physically and mentally painful, I was literally abused until I blacked out and I am not sure how I recovered. It happened when I was about four. I was taken to hospital and repaired.

I never told anyone. I couldn't trust anyone to tell. Everyone would think it was my fault, I wouldn't have been believed, so I just kept it to myself.

The secrecy that surrounds CSA coupled with the criminal restriction on such behaviour and the repugnant feelings and emotions that may surface when speaking about the abuse, all conspire to silence discussion and dissuade disclosure. Many adult survivors of child sexual assault speak of their experiences of being blamed, ridiculed, or shunned, when they tried to disclose ^{1,82}. Survivors may not disclose or report because they fear repercussions, and can be overwhelmed by intense feelings of guilt and shame. Others note that children may not have the language to describe what is happening to them ⁵¹. Aannee Brown was 15 years of age when she became pregnant with her father's child as a result of ongoing sexual abuse over many years. She presented to a doctor who asked, 'With whom have you had sex?' and she had no idea what the words 'have sex' meant ¹⁵¹. She had been kept isolated from other people, living in remote areas, without television and radio, so she had limited vocabulary to describe what was happening to her. First-point-of contact professionals need to be aware that CSA could be the reason behind a variety of interpersonal, behavioural and psychological problems that they are witnessing in adults and children. They must provide their assessment questions in a variety of ways so the child/woman has multiple opportunities to give expression to her experiences ^{152, 153}.

Survivors of CSA use the protective defences learned in childhood such as denying, minimising, or dissociating to cope with their situation. Thus acknowledging the impact of CSA and disclosing are difficult tasks that women seldom undertake unless they feel safe and ready, or they are specifically asked about CSA ¹³⁵. Fleming suggests embarrassment or shame (46%) are key reasons women will not disclose, followed by the belief that the other person will not be able to help them (23%), or will blame or punish them (18%) ⁶³. The experiences of the women in this study confirm these findings. They add the need to feel listened to and safe, is of equal importance.

The main reason I couldn't take it further was because if I said something, then Family and Community Service would be brought back into it, because my brother's still under the Guardianship of the Minister and there's the chance where even though he's (foster father) in jail, my Mum would lose custody of my brother and that would just be the end of everything for her and for my brother. Sorry, I couldn't do that.

He had a knife held to my throat. Then I realised that if he was really going to kill me he would have done it already. I had had enough. I couldn't stand it any more. I knew it wasn't my fault it was happening and I didn't want it to go on anymore. I couldn't handle it anymore. It got to the point where I wasn't worried about him killing me. I was worried about doing harm to myself...so I told someone.

There are several factors that may prevent a professional from listening and acting on a survivor's disclosure. They include the gender of the person disclosing, finding the topic of sexual abuse too abhorrent to talk about, or over identifying with the person's experience for personal reasons ¹⁵. However, more commonly the reasons are fear related. Fear of the consequences of listening, of addressing a topic as 'specialised' as CSA, of inserting false memories, and of appearing accusatory ^{56, 154}.

Perpetrators

Again this research could not provide an exhaustive literature review on the plethora of articles in the criminal justice and legal literature around perpetrators or offenders of CSA. What is important to note is that sexual abuse occurs to children of all ages and both genders. It is committed predominantly by men, who are most commonly known to, or related to the child, or are trusted adults in positions of authority. Generally the parents of the child know the child is spending time with that person ^{110, 155}. Research indicates that more than 50% of all assaults take place in a private home ¹⁵⁶. The stereotype of the perpetrator as a 'sleazy old bloke' may be misleading, because it is estimated that approximately 25% of offenders are adolescents ¹⁵⁷.

Male perpetrators of CSA are a heterogeneous group and to date no consistent profile of a child sexual offender has emerged ¹⁵⁸. There is some evidence that the perpetrators within the family, are also offending outside of the family ^{155, 159}. There is no uniform class, age, race, ethnicity, wealth, intelligence, education, occupation, religious, family or mental health status amongst perpetrating offenders. Offenders are located across the entire cross-section of the population ^{160, 161}. Typology frameworks are constructed to work out why offenders abuse children by focussing on who are the perpetrators ¹⁵⁵. After extensive research into the area of criminal profiling of CSA offenders Wurtele and Miller-Perrin ¹⁶¹ noted the only common denominators were the offender's lack of sensitivity to the child's desires and requirements, and a readiness to take advantage of the child's trust for the offender's personal indulgence, revenue, or self-interested reasons.

Females also sexually abuse children, but accurate numbers of female offenders are unclear. Perhaps this is due to the social unwillingness to believe a woman could behave abusively to children^{45, 162 163}. However, society must accept that women are capable of, and do, perpetrate sexual abuse if we are to encourage those who have been abused by women, to safely disclose their abuse¹⁶³. Estimating the real incidence of female abusers is hindered by statistics that classify by relationship, rather than gender^{41, 54}. What is known is that women perpetrators of sexual abuse may work in situations such as day care centres, or take part in organised child sexual abuse groups, or groups that practise ritual sexual abuse of children¹⁶⁴. Fitzroy comments that this is often a manifestation of rage and the loss of agency that is the result of oppression, powerlessness and violence within the woman perpetrator's relationships¹⁶³.

...my real mum and dad were both ...disabled and they had to leave for work early in the morning by public transport and left us with the neighbour. One day when I was about 5 the neighbour came and lay in the bed with me and started touching me. I didn't know what to do. Every day after that happened I use to sit in my room and put a chair up against the door, so he couldn't get in. I used to lie in my bed with my head under the covers. I told my parents about what had happened and from that time on we went and stayed with friends of the family when they left home at six o'clock in the morning. So I was a five year old having to get up and dressed at 5.30am to go somewhere else, so I was safe. Later we were put in foster care with friends of the family and I was staying with them. Between the ages of 5 and 8 my step dad was a model father, I couldn't complain, he was perfect. Then it all changed. I was raped. Then when I was 10 I was raped by someone else as well. The sexual abuse with my step dad just kept on going until I was about 16 or 17.

Early Intervention and Prevention

Critical to our understanding of CSA and service provision is to recognise that much is being done within Australia and internationally, particularly in Canada. It would appear that Governments see the best way forward is to work from within an early intervention and prevention framework that centres on child protection. There are a number of programs working, but it is difficult to estimate their level of success, which is always a challenge for prevention programs. These programs include:

Community education

'Women's Health Statewide' have instigated excellent public awareness campaigns and pamphlets and literature to increase community information about child sexual abuse^{34, 86, 165}. Child protection programs such as the 'Stranger Danger' program are of limited benefit given most children are abused within the family¹⁶⁶.

Parenting ability and support

Programs are being undertaken such as the 'Parenting SA' material which informs parents about ways to construct a safe, protective and trusting family environment which is essential to healthy child development. Children need to be encouraged to speak about their thoughts, feelings and emotions in a safe environment where they are heard ¹⁶⁷. Additionally, parents must be supported in the parenting role and provided opportunities to learn the skills they may lack to provide such a protective environment ³³.

Protective behaviour programs for children

These programs, conducted in schools, should focus on empowering the child to speak out to trusted authorities when behaviour is abusive. Programs need to focus on building a strong sense of self and a clear understanding of personal boundaries ⁷⁵. Persons delivering such programs need to be educated in varying strategies to get this message through clearly and in a way that school policies reinforce such behaviours.

Government funding

Adequate funding for well devised innovative and inclusive prevention programs that are cross-cultural, and consistently delivered, via schools and community venues ¹⁶⁸.

Identify behaviours that should alert first-point-of-contact professionals

Health professionals, teachers, child-care workers, carers, and those within the police force, must be appropriately equipped with the knowledge and skills to identify, support and manage children who they suspect may be, or have been, sexually abused ^{56, 169-174}. 'Women's Health Statewide' have taken on the work of educating health professionals, but gaining interest and entry into an organisation to educate on this topic, is not as simple as it should be ³⁴.

Selecting and screening workers

This state has introduced police checks on salaried and volunteer workers who have access to children. This needs to extend to similar community groups. The Queensland Government now have a 'Blue Card' which is issued to every person working with children in that State.

Ongoing therapeutic services for CSA survivors

Given the documented evidence of the insidious impact and long term effects of CSA, survivors need to be able to access support where they can work through their life issues and challenges, as they surface ^{169, 174}. This may well prevent the documented evidence of repeated re-victimisation ^{32, 33}. For example the unwitting display of sexual behaviour of a CSA victim may place the child or adolescent at great risk. Without appropriate intervention, the child who is a CSA victim may normalise sexual

behaviour that puts them at risk of experimenting and playing with their friends and relatives in ways that perpetuate the possibility of sexually abusing others. The child will only do what they know, thus it is important that such children are supported with values education and behavioural modification programs that improve their ability to respect and maintain their own, and another person's, boundaries.

Working with perpetrators

Effective treatment of perpetrators may help them not to re-offend against other children. This is an important aspect of a well rounded prevention program ¹⁷⁵⁻¹⁷⁸. There is evidence that supports the notion that recidivism rates are reduced by rehabilitation programs and new programs are being employed within Australia at present ^{160, 179, 180}.

Methods of Working With Women

Herman notes that healing and recovery can only take place within the context of relationships ¹⁸¹. The therapeutic relationship with a counsellor or therapist is not a value neutral zone. Each brings to the encounter personal attitudes and beliefs. Thus watching that these beliefs are not imposed unethically on a client is essential to quality care. Therapists usually want to help clients see particular values in relation to their abuse experiences, but how these are shared is important to the outcomes. For example, when working with survivors or perpetrators, therapists wish to impart a core value that sexual behaviour of any type between an adult and a child is unacceptable. We seek to change the client's behaviours based on development of such a values base. Implied in a therapeutic relationship is a degree of trust and vulnerability on the part of both parties. However, the balance of power in this relationship is seldom equal, thus it should be regularly assessed by the service provider.

Verco states that the language surrounding CSA can place limitations on the healing journey. She discusses the use of the words 'victim' and 'survivor' as two value laden words that place people on an invisible continuum which can shape their healing responses ¹⁸². In such discourses there is little room for the woman's story of overcoming the impacts of abuse with resilient responses that enable a fulfilling and healthy life ¹⁸³. There have been several studies that testify to the healing capacity of groups which are structured as safe places to voice and listen to such life stories and unpack ongoing issues ^{181, 184}.

It is also important to recognise those who work with such incredible sadness can experience what is known as vicarious traumatisation ^{14, 15}. There is no doubt that hearing and thinking about the

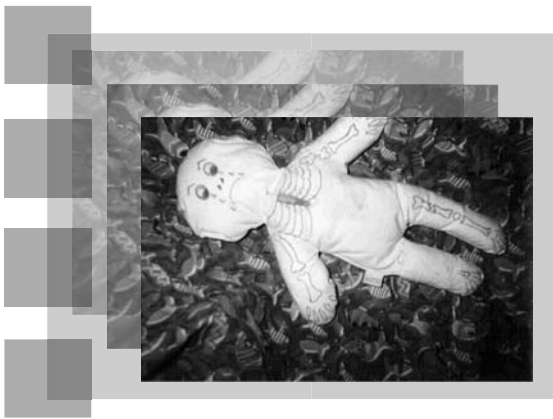
stories one hears can continue well after the client has left the therapeutic interaction. Having in place mechanisms to support workers seems essential if therapeutic responses are to be expected from these workers ¹⁶⁵. These issues are considered in more depth in Chapter 3 and Chapter 7 of this resource.

Summary

This chapter has provided an overview of the academic literature on the subject of CSA including definitions, prevalence, impacts, and topics such as silencing, disclosure and types of programs and methods of undertaking services to help women overcome their traumatic childhood experiences. It is aimed to provide an overview and background to this project so readers are introduced to the issues that are likely to be part of their work with this group of women.

Chapter 3

Shifting Identity and the Therapeutic Relationship



Who am I as a person?

Central to how workers understand the therapeutic relationship and the experiences of the clients with whom we interact is the notion of self identity. Our identity is the way people commonly present themselves to the world, so that they can be distinguished from, or belong to, other people. Identity is the sense of self an individual creates to signify to others who she/he is, and who she/he is not. Therefore identity speaks to others about who I am and who I am not. The concept of 'self' is stabilised by establishing, maintaining and enforcing boundaries around the self that reinforce the way we define ourselves. Socio-cultural discourses of the dominant culture and the family intertwine with the psychological and biological factors within the child's family to create a complex interplay of familial and extra-familial conditions. These conditions normalise and legitimise a repertoire of responses and behaviours that the child uses to deal with life and recognise who they are. The interactions the child has within the family and with significant others develops her/his sense of individuality, of unity with others, and of continuity in life. Such emotionally significant relationships shape a child's identity.

I don't know who I am. I have never known who I am, because it's always been about them. I've moved into violent relationships because it was about them and that meant I didn't have to face me, because I don't even know where I begin and end, let alone who I am. My whole life I have worn masks and made myself what I felt other people wanted me to be. Now I don't have a clue who the real me is, or even if there is a real me.

The misuse of power by the perpetrator/s of sexual abuse impacts the child's developing identity. The child's capacity to trust and explore her environment, freely using her initiative and growing her problem solving skills, is inhibited by the abuser who usually accompanies his actions with emotional abuse ¹¹¹. If being a self requires establishment of boundaries between your 'self' and an 'other' who can be trusted and respected, then it follows that a child's growth in identity is likely to be adversely effected when the child's personal boundaries are dismissed, violated and transgressed. The perpetrator/s use coercive and manipulative powers to keep the child in the position they desire and in so doing dictate the terms in which the child can make a claim to her identity or selfhood ¹⁸⁵. The child has a confused sense of self, since the perpetrator keeps them in the position of 'other', so he can maintain his chosen identity. The child's place and social functions are always subordinated to the perpetrator's selfhood. This point was brought home repeatedly within the group when women repeatedly ask the question 'Who am I?' and 'Will I ever know the real me?'

This begs the question how do we know ourselves? This question has puzzled philosophers and behavioural experts for millennia with various theoretical positions shifting common thinking over time. Such theoretical understanding underpins the way we help people. There is reasonable consensus in post-modern thinking that the person can only know themselves through their interactions with, and responses to, other humans. They reflect the self via social symbols, norms and mores of behaviour that create the schema that explain what is culturally 'acceptable' and 'normal' behaviour. Accordingly, humans shift their behaviour in response to others, in ways that reinforce the identity schemas they hold for themselves. Such schema are influenced and shaped by the dominant cultural discourses that convey social values and attitudes ¹⁸⁶.

I was a mother, I was a daughter, I was a wife and all of that is being stripped away and I don't know how to face myself as a person.

People feel 'normal' when their behaviours reflect cohesion to the social norms of the dominant culture. In Australian culture the moral discourses that reflect the dominant ideology are conveyed via discourses and narratives passed on to people via the media.

These discourses become socially embedded and reinforced with uniformity of responses over time ¹⁸⁷. For example, notions about gender, roles such as mothering and family life, sexuality, power and authority are socially sanctioned, or vetoed by rewards and reprimands. They are reinforced by social mores that eventually become enshrined in legislation. People feel a sense of cultural otherness when their personal life experiences, beliefs and the schemas by which they makes sense of life, differ from

the core cultural beliefs and norms held by the society in which they live. For example cultural beliefs around gendered roles, sexuality, violence, social responsibility and personal control have proven to be profound issues for women in this study. Without cultural support for alternative understandings, these women interpret their sexual abuse during childhood as personal failure, rather than socio-cultural failure to problematise the perpetrator's abhorrent behaviour. Family values and attitudes can provide some social buffering to these debilitating personal beliefs but this support was unavailable to most survivors in this study. The recent breaking of the silence around CSA has placed this behaviour under the spotlight. How this discourse unfolds within our culture will set the schema by which people judge this behaviour in the future. It is our hope that it will be viewed as a socially reprehensible crime. We hope it will be legislated against, and supported by the capacity to bring offenders to account and expose their behaviour for what it is - depraved, dehumanising and destructive.

I had to do what I was told and I think my confusion was more related to the fact I didn't know whether I was black or white. I was told I was white as a child and wasn't allowed to play with Aboriginal people. Then when I was older I was black and not meant to be with white people...

The Impact of Living with Disruption

As a result of the diminished sense of self, many children experiencing sexual abuse in the formative years of childhood live with continuing disruption and disorientation. A strong sense of self is facilitated by orientation in aspects such as, having a clear sense of who you are, where you are, and where you are going. Such clarity brings an order, integrity and inner peace that promotes health, self-esteem and identity. However, most of the women in this research study live with confusion, disharmony, disorder, disorientation, disintegration, disunity and pain throughout their lives. Consequently, the search for self continues, because the human life quest is connected to the search for answers to the questions 'Who I am?' 'Where am I?' and 'Where do I want to go?'

In western culture, our life search is about our pursuit of meaning, purpose, order, integrity and inner peace, aiming to avoid disruption and disorientation¹⁸⁶. Problems arise when change disrupts the status quo, which forces the end of one way of living that may have achieved these goals. People must then make sense of what has ended and re-invent their sense of self in the midst of these changes. The process of incorporating changing circumstances enables humans to regain a sense of meaning and purpose that facilitates re-establishment of their sense of self via new ways of living. This sounds straight forward enough, except that there are many instances where the options for change are unclear, the choices minimal and the personal capacity to work out what is going on is limited, due to the nature and consistency of change.

I blocked out for years. Eventually, I found I couldn't communicate with anyone and when I wanted to it was like a block and there was no way of doing it. I thought no one really cared about me anyway, so I blocked the pain out again and I became an addict and took lots of drugs and smoked lots of marijuana thinking that was going to help... I would hardly talk when I was living here. Until I opened my mouth and started to talk to someone about it, I realised I had blocked out everything. Going back to it, I have been able to put a light on it. I was able to have a look at it and I can see now just how it has affected my whole life. I found it hard at first.

When disruption has been the background to most of your life experiences, uniformity and stability are a rare experience. The woman may not see any real option but to choose what she knows best, so she will continue to choose discord and disruption and these become her orientation to life. Her early abuse has become her life story, which then becomes the script for the remainder of life. She effectively asks herself 'What sort of things happen to a person like me? What is someone as shameful as me allowed to expect and experience?' Needless to say she answers her questions from a diminished view of self and a weakened sense of self-esteem, so her inner child speaks loudly with responses like 'You cannot be loved! You are unworthy of happiness! You are a sex object! You are disgusting! No-one can ever love someone as shameful and bad as you!' So the growing young woman adjusts her behaviours to fit the schema within her life script. She may withdraw inside herself, fulfilling the prophecy of doom and disgust, she adjusts her

behaviour to fit her life script ¹⁰⁶. Some young women punish themselves with self-harming; others become withdrawn, shy and detached. Some young women develop mental health issues especially relating to body image, which manifest as eating disorders, anxiety and panic disorders. Other young women act out sexually and become promiscuous, while others gravitate toward abusive and violent relationships to complete their mind schema of 'unworthy' ^{90, 122}.

When life is replete with events that rupture the woman's sense of self, she may choose to avoid feeling the ongoing suffering that is disruption. The fear of facing a different way of life can be so intense that she turns to numbing substances such as alcohol and drugs, or activities such as gambling, to dull her pain. If she wants to recover from the use of addictive substances, she has to relearn how to face her fears and experience the pain of the ruptures. There is no avoiding hurt in life, which is a profound part of being human. Disorienting experiences that lead to a disrupted sense of self may facilitate personal growth ¹⁸⁸.

The metaphor of 'seasons within nature' provides a way to picture the possibilities in personal growth that come from adversity and suffering. Autumn brings the disrupting change experience. The change may be chosen or forced. Winter provides a picture of the barren, cold liminal period that heralds confusion and emptiness. The woman must locate what has ended and face that ending. Many women need to withdraw for a period of time to do the self-examination and introspection required to make sense of what has changed and what is happening now, so they can work out how the

disruption has affected their sense of self. People then look toward readjusting the way they live within the world. Spring ushers in the actioning of the proposed new ways of living and being in the world. These actions are undertaken in steps that are tested in the new world in which the woman must now live. The actions may result in the growth and flowering of the woman's identity, but new behaviours are like new shoots, vulnerable to the sudden changes and unpredictable climate of this season. Summer encourages a more developed and fuller sense of self. The woman's identity grows stronger and flourishes in the brighter opportunities that change has brought into her life. The woman locates new ways of living and being in the world that provide the sought-after sense of meaning, purpose, orientation and inner peace that all humans desire. This is the process that this research terms 'transition'.

We could go as far as to say that some women may develop a need for 'rupture', because that is what is known and familiar. Disruption provides the order and continuity in their lives. It is all they have known. They will willingly leave home, family, work places and all that the dominant culture views as stabilising, ordering and balancing, and move into situations where they lose themselves. It is as if the woman's life journey has become a quest to maintain the disrupted self, because this is what provides her orientation and continuity. In seeking disruption she may continue to sever connections to key relationships. She may fear living in a way where a strengthened sense of self has the possibility of increasing her sense of otherness. One may even ponder whether passing through ongoing ordeals confirms to the woman her ability to survive. One may question whether it is the 'survivor' identity that restricts the woman's capacity to live within the social norms of the dominant culture.

An example comes from within the participant group where a woman repeatedly practises self-harm by cutting her skin. When I ask her what she gains from doing this she replies 'I know I am alive because I can see it. The physical pain overtakes the emotional numbness and I feel alive again.' Additionally, when her cut is stitched up the emotional pain disappears at the same time as her physical pain subsides. In effect she is creating a physical rupture to the integrity of her personal boundary, her skin. In so doing she validates that she is alive by disrupting her sense of self to experience her aliveness. Her behaviour is not socially sanctioned in the moral discourses of our dominant cultural mores, but her motivation to feel alive by disrupting her sense of self is found in other more socially acceptable behaviours within our culture.

The notion of disrupting one's sense of self may be the motivation behind cultural tourism within western cultures, where people are travelling in unprecedented numbers to foreign destinations with the purpose of challenging and disrupting their sense of self, so they may feel alive ¹⁸⁹. It has almost become a cultural rite of passage within Australia for younger people to complete an overseas holiday to experience their place in the world. One woman cuts her skin and paradoxically feels alive, another

woman travels to Cambodia to rupture her identity and experience her sense of otherness, with the same motive, to feel alive. Each woman seeks to escape her dulled 'normal' self to experience being alive. Each woman may repeat the behaviour again when she recognises her need to foreground feeling alive.

Sustaining Personal Identity

Psychological theorist Locke noted a strong self-identity was sustained if the person could maintain it in a continuous manner over time, thus the person needs to employ the psychological processes that maintain continuity and sustain identity ¹⁹⁰. He described a human as a thinking intelligent being that has reason and reflection and can consider itself as itself; the same thinking being in different times and places ¹⁹¹. He saw the self as constituted by a series of mental processes that enabled reflection on self. The person is conscious of sensations and has thoughts that are mediated over time and affected by past experiences, thus identity is constituted by recognising that I am the same in the past and present even when my circumstances change ¹⁹¹. He added that the identity of one's self goes back to the extent that our awareness of self can be extended retrospectively, on past actions and thoughts. In this reflection we see the same core self now as we were then and this past self fuses with the present perception of self, to develop a sense of identity that has continuity. He adds that it is not the continuity of body with the person that develops identity, but it is the mind and spirit that define the essence of personal identity, allowing the mind and body to be infused by the spirit which makes the person whole ¹⁹⁰.

Freud on the other hand says the Ego recreates the narrative of its memory, which may lie dormant and repressed within the identity to resurface when one least expects. A person is only aware of fragments of memory selected by the Ego to reconstruct an acceptable narrative that sustains one's identity. The remainder is repressed but it still influences our identity without our conscious awareness. If, as Freud posits, memory is discontinuous and traumatic memories can be repressed, it follows that memories can influence the person at an unconscious level and resurface later when catalytic triggers release them. A process Freud describes as the identity bypassing the Ego ¹⁹². Freud states these memories are not entirely reliable or factual evidence, because they may be implanted in our identity by the person's fantasies and desires, instead of actual factual recollections. It is this theoretical understanding that has fuelled the 'false memory' debate that stymies legal cases and increases the burden of proof of sexual abuse within the legal system. There is a vast body of literature on this subject that is not explored in depth within this study. Suffice to say the therapeutic relationship is impacted by the perspective a professional brings regarding the authenticity and believability of the client's narrative.

The Impact of Shame on Identity

One's perspective of self can change over time based on life experiences¹⁹³. The ability to feel a sense of control over one's self is important to both mental and physical health. In this study the women used the phrase the 'package of feelings' to describe the emotions, feelings, thoughts and attitudes that were associated with being a victim of CSA. This 'package of feelings' continued to influence the woman's identity. It was always in the background of their life story. When it was fore-grounded by the woman's current experience, it dredged up the same 'package of feelings' which focused on loss, grief, anger, guilt, fear, shame and feelings of being powerless. If the focus stayed on these feelings for too long, there were adverse health impacts for the woman. She may feel 'helpless'. This perception impacted the worker's therapeutic efforts and increased the woman's levels of anxiety and depression. Women who continually have this 'package of feelings' fore-grounded, describe themselves as feeling 'confused and overwhelmed' as if they are 'going crazy'. The shame-based identity develops out of the sexual abuse experiences and is often described by the women as self-absorbing, because it keeps the woman's focus on herself as a powerless victim.

... I'm rather ashamed of it (CSA). I think it's been X's (support worker) influence that's sort of helped me not to be ashamed about it. As she's been talking to me I came to realise I am not evil. It's not me... If it wasn't for her, I'd still be rather ashamed I think. Well, even though I hated myself in the past and told myself I was horrible and that, I realise now it's not my fault, I was just a little girl.

Keeping the 'package of feelings' fore-grounded may lead the woman to avoid facing her suffering because she believes it is beyond her control. It reinforces the shame-based identity and replays the diminishing narrative that impinges on meaning construction. She feels unable to choose differently, believing 'This is what I deserve', 'This is all I'll ever be', 'I asked for it'. Such thinking makes her vulnerable to self harm and further abuse, because it reinforces the perception that she is unable to action personal change. The woman may continue to identify with the shame-based identity imposed by the CSA. She may even unwittingly protect and maintain that identity, because the expectations of her are predictable and familiar and she knows how to live and be in the world, with that schema of herself.

There's times when I felt so much shame when I was asked 'What kind of mother are you?'... I went so low mentally and spiritually, that I got to see the world's end was near for me. Then I recognised it was not going to be a better place without me and my kids were not going to be better off without me, no matter what happened. They needed their mother in their lives. So now I think, even if I can give them a little bit, it's something, and that is better than nothing. I got nothing from my parents – just abuse, so I want it to be different for them. As long as they can see I love them and I am trying to do my best for them. I am leaving shame behind because shame is the most debilitating feeling I've ever known in my life...shame paralyses your ability to do anything.

Fore-grounding Abuse to Shift Identity

In the therapeutic relationship the abuse is deliberately and carefully fore-grounded in a most supportive manner so the 'package of feelings' is located, exposed and explored within the woman's narrative so she can make sense of her current experience in the light of her former story. For many women participating in this study, this has been paradoxically painful and difficult, and revelatory and healing. Focussing on the feelings and linking them back to the past experiences allows the woman to identify her emotions, thoughts, feelings and attitudes that are grounded in the shame-based identity which grew from her abuse experiences. It highlights their ongoing toxic impact on her sense of self and in so doing she is able to start separating herself from that 'package of feelings' related to the CSA. During the ongoing exploration, the woman seeks to identify what changes are occurring. Her newly forming sense of self is fore-grounded and reinforced, while simultaneously unravelling the shame-based identity of the sexual abuse victim and moving her into the background of her mind picture where she has less destructive influence over the woman's current self.

With this developing sense of self, wellness is fore-grounded and the 'package of feelings' surfaced by abuse loses the capacity to disrupt as readily as it has in the past. That is not to say that the woman does not unwittingly 'step back into the pit' from time to time, but she may recognise where she is. The woman is able to draw on an alternative sense of self and find strength and resources in her newly forming identity, so she recognises what she needs to action to move on. One woman described it as a new identity that is 'set like wobbly jelly that can melt when the heat is on'. However, instead of turning to past addictive behaviours as the best response to handling 'heated situations' which trigger the 'package of feelings', the woman increasingly sees herself as free of such disempowering responses, preferring to make choices that develop her newly discovered sense of self.

The process of self discovery may be facilitated by support groups where a woman's new sense of identity can be reinforced by others in the group. The CSA is fore-grounded for a time but only to help make sense of the impact it has had on the woman's sense of self. As she becomes stronger she may distance herself from the worker or support group, or alternatively she may become strong enough to support others in their transition process within the group. This distancing allows her to focus on developing the emotional, social and spiritual aspects of living that have been stymied by the shame-based abuse identity.

One common threat to keeping this new sense of self strong and shifting the perspective where the 'package of feelings' relating to abuse are fore-grounded, is the threat to personal control over

the woman's newly forming sense of self¹⁹³. These threats can include: threats to basic needs such as safe housing; financial difficulty; threats to important social relationships such as parenting; the use of abuse or addiction related labels, or stigmatising behaviours from other people; and insufficient skills to manage the changing self (Eg assertiveness skills, communication skills, conflict resolution skills, boundary assertion, interpersonal skills that are essential to asserting her new sense of self). Interactions with people that reassert the victim identity and its incumbent hopelessness and disempowerment readily surface the 'package of feelings' associated with the shame-based CSA identity. The cumulative effect of several of these threats can be enough to surface the old 'package of feelings' that trigger confusion and a sense of being overwhelmed. If the woman does not have the support or personal resources to do the sense making activity required to choose actions that affirm her developing sense of self, she may well react from her former patterns of behaviour that could include using alcohol, drugs, gambling or other high risk behaviours.

This group has made me so strong... and for the first time I read the feedback like it was talking just to me. I had no guilt, no hurt, or no pain. I read it over a period of three days. I sat there knowing that I was a different person. I was finally separated from the past. All I am doing now is making me stronger and making me move forward, because I am facing my pain and shame and guilt and dealing with it. I am starting to find the real me!

Obtaining Support to Shift Identity

The woman will seek support from the worker/group that reinforces the message she wishes to have fore-grounded. For example, if she wants to maintain an abuse-in-the-foreground focus, she will probably choose to maintain the circle of alcohol/drug using friends in her life. If she is dealing with her addiction, she may find the support of a 12-step program, or an addiction treatment service useful. She may want the worker to help her see the influence of past abuse on life choices. The worker can focus her attention on unpacking the abuse rather than a more general approach that focuses only on the presenting problem. Support groups may provide the motivation and shoring up activities she requires to do that unpacking. Hearing from people who have had similar life experiences can provide powerful reinforcement of an alternative and hopeful story that provides the motivation and impetus to do the hard work of facing the past. As her sense of identity becomes more solid, she may choose to have her worker fore-ground her new identity and focus less on the abuse and more on strengthening her developing sense of self. Most professional workers will recognise the woman's changing sense of self and alter the focus of therapy as the woman identifies her needs. This is more likely to happen with an individual worker than a support group.

When I went to X, I spent a lot of time alone. Then I started seeing a difference in people's responses... I started sorting out the clatter from the music basically. You know when some people talk it's like clatter, but when other people talk and there's a sense to it. It's music, so I can begin to find my own melody...

It is important to recognise that at any time there are optimistic and pessimistic shifts in perspective within the transition trajectory. The healing activities that occur within the therapeutic relationship depend on how the worker provides the space for the woman to explore her life narrative, so she can make sense of what is happening using new knowledge about her past and current situation. In so doing the woman will seek to maintain a near and hopeful goal that can shift her to a more optimistic view of herself, her strengths and abilities, so she manages her current situation in a life affirming way.

What Does the Worker Bring to the Therapeutic Relationship?

In a therapeutic relationship the service provider respects the client and seeks to address her needs, wishes, concerns, values, priorities, points of view and strengths. The worker provides a safe holding space for the woman to be heard and unpack, explore and hear her story. As a worker you care for the client as a fellow human being, not as a presenting problem. You follow the woman's lead regarding her need for information, conversation and decision making about ways to move forward with her current situation. In a therapeutic relationship you operate from a paradigm that embraces the client as the person best positioned to know what is needed in her life. You then work to empower her to play an active role in her own decision making. It is important to role model how this is done. You may even have to help her make decisions if she is vulnerable, confused or traumatised and cannot undertake this process for herself at this time. You should help the client define her goals and discuss with her the ways she might action her choices.

With clients who have experienced abuse and violence it would appear prudent that the client receives care from the same case worker as much as is possible and that her needs are addressed within a timely manner. The woman lives in relationship, so you must consider the needs of the woman's family and significant others in options that she canvasses. However, the needs of significant others are subordinated to the woman's needs, unless the safety of another person is likely to be compromised. If the woman wants her family involved in her care, it is her choice to say how this involvement should look. She will need to consider all her options and their likely outcomes. As her worker, you should support the woman by listening and providing a healing and safe space for her narrative to be articulated, validated and explored. You can provide information as required, advocate for resources and assist her to address her unique needs.

Fundamental to the therapeutic process is the protection of the rights and wellbeing of the woman as a client. As members of a professional group, you must practise in the best interests of your client. This includes assessment of her needs, and the risks, benefits and alternative methods of any therapy proposed. Take into account your level of expertise, experience and resources and those of your client when making such therapeutic plans.

I notice that the more personal power I show as I am growing, people are changing toward me. They respect me more. I've seen reactions change when I am assertive. I first thought it was people who had changed, but it is actually a change in my attitude! People respond differently to you. Suddenly you're trying to claw back some power that you've never had and assert yourself, and it confuses some people because you're behaving in a way that they don't recognise. People respond to you differently. It'll either be too much for them or they'll re-negotiate a different sort of relationship with you. That's what you're trying to do and that has its own challenges, especially within families.

Professional Boundaries within Therapeutic Relationships

Professional boundaries define this relationship and dictate the establishment and maintenance of appropriate behaviours between you and your client, to sustain a safe and effective healing relationship. Professional boundaries are most often compromised by either party imposing personal values or attitudes that interfere with the therapeutic aims of the interaction. Other compromises may include giving or receiving of money or gifts that may develop conflicts of interest.

The establishment and management of a therapeutic relationship require consideration of the woman, the organisation, and the social, cultural, religious and professional aspects of the professional boundaries between the worker and client. Naturally some flexibility is required to accommodate the changing nature of a therapeutic relationship. The worker must remain cognisant of her/his legal and professional standards and codes of conduct. The safety and well being of the woman is assured through a therapeutic relationship that respects and adheres to current professional practices, recent and up-to-date knowledge, and adherence to the guidelines, codes, policies and procedures that govern professional conduct in your discipline. As her worker you remain responsible for the management of the therapeutic relationship and the maintenance of professional boundaries.

Safety, trust and ethical behaviour underpin the therapeutic relationship. You are expected to regard and respect client disclosures, refraining from discussing confidential information outside of appropriate forums. There are potential risks associated with all interpersonal relationships and the use of touch and personal contact within these relationships needs to be sensitively managed

to minimise risk situations. It is important to ensure personal self-disclosure is appropriate and minimised to occasions where it assists to achieve a therapeutic goal. You should check judgmental attitudes, the desire to probe for unnecessary information, and reflect on your practice to check for shifts in personal attitude. As a worker you are employed because you have certain effective listening and communication skills, which you must use to effect the woman's healing. You should remain assertive and utilise negotiation, mediation, advocacy and confrontation skills with the woman and the services she may need to employ to advance her healing.

Reflecting on Your Personal Values and Attitudes

This project noted some undesirable first-point-of-contact experiences where workers personal attitudes served to label, discriminate and diminish the woman. As one woman noted *'They seemed hell bent on destroying every last shred of dignity I had, and crushing my spirit. They discussed my diagnosis, just as if I was not present. I felt so humiliated'*. In places such as emergency departments, with police workers, with some social support services, woman had an array of stories depicting diminishing and unprofessional experiences. The most common factors present in these situations were:

- the woman had little or no opportunity to articulate what she needed;
- she was disregarded and ignored in discussions about what should/could happen in her own care;
- her specific requests/instructions regarding visits and contacts from the perpetrator was not respected and even disregarded by some staff; and
- she heard workers speaking about her case in public forums where many people could hear her story, thus breaching her legal right to privacy and confidentiality.

It is impossible to have a therapeutic relationship with a client if the fundamental values of respect, trust, dignity and safety are compromised. Many of the women survivors in this project have experienced re-victimisation via rape and assault as adults. They spoke with passion about how hard it was when they were met with responses like 'What the hell is wrong with you, why don't you just leave?' from police and hospital personnel. One woman commented 'I said to her why should I have to leave! It's my home! Why don't you take him away and lock him up! He's the one who's violent and he's my problem!' She explains further,

It is my home, my children's home and leaving that place means I give up my own territory. This is what I know, where I am comfortable. I should not have to leave. It is the perpetrator of the violence that should be removed, but the justice system is crippled when it comes to doing that. It's much easier to blame me for not leaving. I have tried to leave, but it is

extremely difficult to do. I see my children uprooted, dying inside, missing their friends and school, their hearts are saddened and broken. So it is just easier to go back to what is familiar, for their sake, and take the violence and abuse. When you stay in that violent situation your mental state deteriorates to a degree that you can't function. It seems to be too hard for workers to understand that I just want the violence to stop, but I don't necessarily want to leave my home and my family. In the end I had to become homeless and leave all my children, because I could not get support until I became homeless.

Needless to say, workers of all disciplines need to be aware of their personal values, stereotypes, labels and knowledge assumptions. The women in this study are hoping that this resource will open the eyes of workers like you, and other interested readers who have the power and the capacity to intervene and make a difference. They want their stories to impact your attitude so you can work to change the future for other survivors.

Reflecting on Professional Boundaries

It may be worthwhile to take some time at regular intervals to consciously reflect on your personal and professional boundaries. The following questions will assist:

- How are your social relationships similar to, and different from, your client relationships?
- How are your intimate relationships similar to, and different from, your client relationships?
- Reflect on your perspective, considering myths, labels, stereotypes in the following areas as these will affect professional boundaries:
 - o How do you view CSA?
 - o How do you view addiction?
 - o How do you view homelessness?
 - o How do you view mental illness?
- What is your preferred style of communication?
- Do you hold a professional stereotype of a survivor of CSA?

Example: One woman noted that there is a tendency for workers to view all women who come into supported accommodation as weak and vulnerable, which can result in some women feeling a pressure to conform and modify their coping behaviour to appear weaker, so they qualify for support.

This may be because many women who come into supported accommodation have lost their voice. When they speak it's often from a disempowered position when they arrive in the supported accommodation. They seem to take a subservient position and become compliant. Therefore when a woman presents with confidence, behaving assertively and in an articulate manner, the worker must readjust to her behaviour. If the worker does not adjust, it may trigger an angry response in the woman. She perceives that the workers view her behaviour as 'attention seeking', or they assume she has more power over her situation than she actually has.

As this participant noted, 'It didn't matter how much I modified my behaviour as a child, my dad still did what he did'. Therefore she stopped trying to be accommodating and became rebellious and intimidating. She learnt that being untouchable was an effective method to keep safe. Consequently, modifying behaviour to accommodate others may not be considered an appropriate option for a woman when she first seeks support. Such behaviour may be labelled by workers as 'attention seeking', 'aggressive', yet it could well be the way this woman is saying she wants help. Personal opinions do matter, and the workers values, attitudes and beliefs are transferred into behaviours within the worker/client relationship.

Barriers to a Therapeutic Relationship

Climate of trust

For most survivors a common issue when seeking help is the inability to trust people, because trust was violated in past experiences. This lack of trust can extend to workers, or a group.

In some situations my instincts tell me that I can't open up and say what I want to say, but I really need to. It is not being able to trust adequately and feel that you are on a platform where you have enough respect to function safely and clearly.

When a client is unsure of safe limits, she is sensitive and careful of how and what she says, because she knows it affects others. The woman judges your reactions to the interaction as a measure to stop or move on with the therapeutic conversation and healing activities. Her confidence improves with thoughtful, respectful and caring responses. However the social dynamics of the place where she lives and the people who are put in place to help her, can be very variable. Consequently, a woman may test relationships for authenticity and safety before she entrusts her story to you. She will test the conversation by sharing limited information first and then challenge you, to see how you are listening and responding. Survivors of CSA have refined intuitive and observation skills and can quickly discern nonverbal signs and body language that demonstrate whether you are present, aware, listening or

just hearing. Based on those responses the woman may disclose, converse, challenge or not. If the interaction is unhelpful she will lose confidence and trust, and her sense of self-identity will be challenged. The women noted that they leave such interactions feeling 'broken' and 'disappointed'.

Readiness

Before a therapeutic relationship can occur the woman needs to be ready to begin this relationship. Being ready and prepared to work at remembering and healing is a process that requires energy, safety and stability in both the family and personal situation. The woman may be unaware of how to get help and look for it in different ways. For example she may present to the doctor frequently with minor ailments, or she might be self-harming in some way. One woman said she did not know how to ask for what she wanted. Another woman said she didn't even know what she needed. Others said they didn't know where help would, or could, come from. The older women in the group said they were seldom asked about CSA by health and social service providers, however, on the occasions that they were asked they would divert the conversation to something else. They found it very hard to go there and speak about CSA. Most women said they could not talk about CSA unless they actually 'psyched themselves up for it'.

There were examples of astute workers who helped women find ways to voice their experiences. These workers commonly acknowledged the woman's strength and courage to speak out and seek help. This helped the woman to name and give a voice to her experience. These workers allowed the woman time to speak, were attentive to her story, demonstrating they believed the woman. They seemed to 'know what to listen and look out for' and they interacted with the woman in a non-judgemental, accepting manner, giving her the time she needed to express her concerns. They acknowledged the difficulty a woman had in speaking about her sexual abuse and the problems she had in naming what was happening, or had happened to her. One woman called it 'compassionate empathy'.

I think because I left home at 15 and went up to Sydney and worked on the streets stripping... I had so many other problems as well... I had been raped a few times up there... so it all just got pushed under. I had to deal with all the stuff that happened up there, as well as the past. There was never any inclination to talk about it...

Perhaps the final word about the therapeutic relationship should come from the women themselves:

We are very insightful about people's professional acceptance and presence. We need to be believed above all else, so we would only tell someone if we were reasonably confident we might still be accepted and definitely believed. We can tell when someone is disinterested, nosy, perhaps even voyeuristic, judgemental, or labelling us from their text book reference list, instead of listening to our life references. Our life experience has shown us that people often have ulterior motives and hidden agendas when they deal with us. This has made us insightful,

even suspicious at times and afraid of people who want to know too many details. We find ourselves asking "How are my details going to help them, and me?" We are worried about not being believed, or being blamed, or judged. Sometimes people do this without realising they do it by asking questions that start with 'Why didn't you...' and we walk away feeling blamed again, as if we asked for what we got.

Being free of the fear of repercussions from workers, family, friends, employees, and the society in which we live helps us feel safe enough to face our pain. Knowing we are going to be safe and supported for long enough to face our pain, allows us to go there. We know the well of despair, anger and desperation that gets stirred up when we talk about our childhood and the sexual abuse, so we need to have several close follow-up appointments immediately after we first disclose, otherwise we can't go there. There is no point disintegrating in front of your psychiatrist and then leaving after an hour to face your home situation in a complete mess. How will they know why you are in such a mess? I have been seeing the same psychiatrist for the last eleven years off and on. When I first started seeing her she said, "We really have to get to the crux of this child abuse thing". To this day I still have not spoken to her about it. Whenever she thinks I am getting to a level where I could cope with it and she brings it up, I can't go there, because I don't see her for another six months and it's just not possible to talk about it in this way. I can't stand all the feelings that well up within me when I talk about the past. So the system doesn't help me to talk about it. Maybe she doesn't want me to talk? That thought has crossed my mind you know. If she wanted to discuss it with me, she would do something about the way she structured the appointments wouldn't she?

The Qualities of a Therapeutic Worker

The most important aspect of a therapeutic worker is someone who makes the woman feel safe. Any woman, who has been extremely hurt by other people, especially when she has been systematically abused, has probably learnt that it is not safe to trust anyone. This is how she survived. She may not trust you, her worker, for a long time and perhaps she will never trust you completely. Moreover, in her world where brutality, horror and extreme danger were common place, talking about safety can seem absurd, or even offensive. You can and must help her to feel safer. You can begin by performing simple acts of kindness, by demonstrating in your attentiveness that you care about her. She needs to know she is going to be respected, accepted and that her privacy and confidentiality will be unequivocally respected. As a survivor of abuse and more particularly sexual abuse in childhood she needs to know:

What general approach to counselling you will use. What role does she have, and what are her rights and expectations within that role.

You will respect and protect her boundaries. The trauma of CSA breaches normal boundaries and shatters the sense of protection, safety and self. The woman needs to know her wishes matter and that you will not force her to respond in anyway other than how she chooses. She needs to know there will be no invasion or incursion of any of her personal boundaries.

She can leave at any time if she wants/needs to. A woman who has experienced abuse may need reassurance that she is not trapped and that she can leave any interaction without fear of reprisal or recrimination, whenever she wants to.

She will not be touched if she does not want to be. Some women who have learned to associate touch with violation often struggle to be touched, even in kindness. As her violation was sexual she may not tolerate intimacy, even when it is well intentioned, so always ask before touching.

She needs to feel accepted and not judged. This woman may experience a lot of feelings and sensations she does not readily understand. She is a harsh judge of herself and may punish herself with diminishing self-talk. She needs those around her to accept and affirm her as valuable and worthy, and not as an object that has been 'ruined', 'used', or 'tainted' by what she has experienced, even if that is how she feels about herself.

She needs the space and time to talk, and be listened to. It can be difficult for you to hear the woman's story, especially when her story is more than you can stand to hear, or think about, and stirs deep emotions and feelings within you. It can just become too difficult to listen to... but a compassionate holding space where she may be heard and believed is one of the most important things you can offer.

She needs attention paid to her feelings. When a woman is hurting in ways she cannot understand, she may dissociate from her feelings. She may numb or freeze her emotional attachments in order to survive. It was a survival response to helping her live through the traumatic experiences of CSA and may continue into adulthood. However, these responses do not work in an adult world where she needs to be a responsive partner, friend, lover, mother... She may need to learn to reconnect with her feelings and emotions, to start experiencing her sentient self again. Then

I've been able to forgive.....I've been able to feel mercy towards him and every time I think about my kids, I think that he was just a sick man, you know... he couldn't help it. I have more compassion in me. And I honestly think that that's because when I busted you showed me compassion... for me to be able to turn it around required personally experiencing it myself you know. I have more silence in me now... a peace. I don't have that agitation as often.

she may function in a responsive and safe manner, rather than living in a semi shutdown state inside herself.

She wants the worker to challenge her responses and behaviours in a fair and responsive manner that frames her actions within a broader social context. She does not want to be challenged in a manner where she feels blamed, or where her integrity is compromised. She will appreciate your ability to confront her gently, and with compassion, so she can situate accountability where it belongs... with the perpetrator/s. Transparent and therapeutic conversations require you to enact very careful responses and questioning techniques.

Sometimes she will need to be left alone. You should never force help on a woman who has previously been forced by people to do things against her will. Sometimes the woman is not ready to begin a process of exploration, or be ready to talk about what has happened. It is always important to respect her choices about her healing processes. Each woman needs to heal in her own way and in her own time. She may need to feel, or she may need to remain numb for the present. The best approach, when you are uncertain about what she wants, is to ask. Ask her permission to talk about what happened, to talk about her feelings, or to ask her what sort of support she thinks might be most helpful for her now. It is almost always damaging when a worker insists that they know what the woman needs, better than she does.

The women in this study were very clear as to what qualities they found in the therapeutic worker with whom they could establish a healing relationship. The qualities derived from interview and group transcripts are compiled into Table 3.1.

Table 3.1**Qualities of a Therapeutic Worker**

Having my story believed and showing empathy for my experiences	The worker is approachable and understanding	Accepts me as I am
Trustworthy with what I disclose	Confidential with my story	Does not talk about me or to me like I am a freak show exhibit
Is respectful of me as a person and my choices	Is available when I'm there and I can get an appointment with them	Is honest with me about my choices and options
Supports me to meet my needs, my roles and my life relationships	Being really listened to	I'd like them to be skilled at what they do so I'm not the guinea pig
Is relaxed with me so I feel relaxed and able to speak	Aims to meet my needs	Gives me advice when I need it or request it
Acts as an advocate in situations where I need that help	Assists me in mediation especially about my basic needs Eg. housing	Shows they understand me and my situation
Helps me to speak out distressing thoughts and feelings	Assists me in the sense making process	Acts as a role model and assists me with problem solving
Helps me recognise my strengths, assets and my self-defeating behaviours	Helps me find alternative behaviours that build my sense of self	Promotes my ability to care for myself and maintain independence
Tolerates my backsliding and stuffing up	Has some flexibility about appointments	Is safe and protects and respects my boundaries
Provides an open, honest and transparent professional agenda	Believes in me and my ability to move on	Uses my name and remembers it
Keeps me informed about issues that impact my life	Optimistic about my opportunities to heal	Maintains hopeful attitude about therapy
Doesn't label or stereotype me or my behaviour	Doesn't impose values but shares them as ideas and possibilities	Has a level of awareness about her/his own self and personal issues

What the Client Brings to the Therapeutic Relationship

Finally, without a willing and able client there is no therapeutic relationship. Each woman brings to the therapeutic encounter her own story and experiences. She may be in touch with her story, or she may be struggling to engage with her own narrative. This readiness to participate will depend on her personal values, beliefs, knowledge, attitude, relational connections, capacity, resilience, health and motivation. These qualities are considered further in the following chapters as the transition process is explored, but their meanings are briefly described below within the context of the therapeutic relationship:

- **personal values:** the thoughts and guiding principles the woman views as important, helpful and useful to direct her responses and behaviours;
- **personal beliefs:** the framework that provide the truth and certainty to the woman's life;
- **knowledge:** the woman's understandings and information about herself and the world in which she lives;
- **attitude:** the feelings and opinions that the client holds about various aspects of her life and personal experiences, which affect behaviours, reactions and responses;
- **relational connections:** the significant others in the life of the client such as family, children, partners, support people, sponsors etc;
- **capacity:** the amount of issues a person can deal with and her particular ability to do certain activities;
- **resilience:** ability to bounce back or return to an incorporated state after adverse circumstances and perhaps even locate solutions and responses in the face of hardship;
- **health:** freedom from illness and disability that would adversely impact the woman's ability to work through her current life issues; and
- **motivation:** the woman sees the reason and need to work through her current issues and behaviours. This motivation can come from within the woman or from outside of her.

Suffice to say, the woman who is willing and able to share her story will in the telling of her narrative reveal the kind of strengths she used to survive her ordeals, to get on in the world, and persevere. She will say what people and situations she watched out for, and highlight actions that were memorable or remarkable in her story. In the telling of her story, she will remind herself of who she is, and who she is not, and what aspects of her identity are valuable enough to keep, in her ongoing story. The telling experience is valuable because she sees her story as worthy of being heard and her reality as respected, and herself as affirmed¹⁹⁴. In the telling she gains legibility, recognising where she has been, reclaiming aspects of herself that she wishes to take into her future. The retelling of her

story places different emphases on aspects of the story so she gains fresh understandings. In the telling she rediscovers things that matter. She presents her story to the group or the worker to ascertain their values, and then shapes her responses to the affirmations and feedback she receives from the hearers.

In this project the women found the opportunity to tell their story facilitates the reclamation of their identity. When hearing her story, and interacting with others about her story, the woman locates values within that story which are important to her sense of identity. Bauman says the identity building aspects of story telling come from the opportunity for the inner self to come out and locate an identity outside of one's self ¹⁹⁵. The healing aspects of telling one's story come dialogically because the teller constructs in her story a sense of authentic self which she locates within her story. The group and the worker reflect the strengths in that story back to the woman. It is important to emphasise that the worker listens for opportunities to highlight strengths and reshape negative constructions into plot lines of resistance and strength. The woman discovers aspects of her authentic self that have been subverted and repressed by the continual fore-grounding of her abuse story ¹⁹⁶. In her interactions with others she reveals her concerns, her values, her attitudes, her resilience etc. The women in this study began to reclaim and recover themselves in the story telling process, discovering they were not the sum of their abuse experiences, nor were they that 'package of feelings'.

I have really lost touch with myself. I know this... I am feeling sick and it is getting to me... like it was very hard to get here today 'cause I have to keep going "I'm gonna be sick, I'm gonna be sick, I'm gonna be sick", but I just kept walking here... I don't even know what all this sickness is about. It's anxiety. It's obviously a battle inside of me to go forward, or to go back to the way I was.... And I don't want to go back and isolating will send me back...

I'm dealing with seeing my children again after a few years. I'm dealing with my problems. I want to get it sorted out. No point in tucking it away and hoping it goes away any more, because it stays there to spoil every relationship. You know, all the years of keeping everything to yourself and doing the rebellion thing, when you're faced with this opportunity, it's like, where do you go with it? You need someone to help you sort the dirt from the gems, and a good worker and this group are helping to do that.

Summary

This chapter briefly examines aspects of how identity is shaped and the importance self-identity has in situating one's self within the family and society. The disruption of sexual abuse and the effect of concomitant shame on identity, highlights the adverse effects that fore-grounding sexual abuse and its impacts continues to have on the woman's sense of self. Against this understanding we explore how the therapeutic fore-grounding of the woman's CSA story can be used to shift her sense of self identity within conversations that take place in a therapeutic relationship. We addressed the qualities the woman and the worker bring to such a relationship and posit some guidelines for working together to develop therapeutic conversations based on our research findings.

Chapter 4

Recognising the Disruption: Looking



Introduction

Women's stories of CSA are stories of gross disruption and in essence, stories of difference ¹⁸⁸. The women measure themselves against a backdrop of societal expectations and standards which they perceive as 'normal'. They use images, ideals and values that have salience for them as they define normality. The process of 'Look, Think, Act' described in Chapter 1 may be a simple and helpful way of working with women to explore and deconstruct understandings of 'normal'.

Humans all experience things they cannot understand and interactions with others can help people to see their situation in a different way that might enable healing and personal growth. In the therapeutic relationship described in Chapter 2 you, the worker, aim to facilitate the process of 'Looking' to help the woman build her picture of what is happening, and in so doing, recognise the issues and problems within her story ¹⁹⁷. In this exploration process the worker seeks to reflect back to the woman aspects of her story that she may have taken-for-granted. You help her to narrate positions

of her everyday reality, so she can consider alternative possibilities that she may not have noticed before. In telling her story the client may bring up unquestioned assumptions, views and beliefs that can be laid open for inspection. This chapter outlines that 'Looking' process that begins the sense making journey.

In Chapter 3 we discussed identity formation and the human quest to understand 'Who I am'. We looked at the impact of disruption and shame on identity formation. Humans need to know who they are, and who they are not, to gain a sense of belonging with, and being different from, others. However, people can be bombarded with contradictory and confusing personal thoughts, feelings and emotions and it is not always that simple to identify what you are feeling, let alone why you feel that way. This process can take time and energy, but in this study we found that a systematic and simple process such as 'Look, Think and Act' can give an effective and uncomplicated framework to the sense making process that sustains identity.

Behavioural psychologists note that a child's self-concept is factual. For example the child describes herself in terms of gender, hair colour, eye colour, complexion and relationships. As the child becomes an adolescent she may add personal thoughts, feelings and attitudes to that description of herself. Later moral perspectives and judgements will be added. The behaviouralist perspective says the child's growing knowledge of self is achieved via introspection and observation of her own behaviour and its impacts ¹⁸⁶. Those following a humanist psychological paradigm focus on personal agency as the way the person gains knowledge of self. Needless to say women who have experienced limited agency as a result of years of abuse during childhood will have decreased agency. This study used a social-constructivist approach to underpin narrative methods of working with women to help them to see the interrelationship of self and language, and the social structures within language (her own and other people's language) to locate constructions that diminish or nurture the woman's sense of self. Thus the focus of dialogue is the woman's perspective of how she sees herself. We focused on the meanings and interpretations she places on her story of what has happened, and is happening within and around her. Human experiences are made up of meaningful actions and interactions over time. Therefore the way we work with women to unpack their story and deconstruct aspects that each woman finds meaningful, facilitates her quest to locate herself. With facilitation the woman reconstructs aspects of her story that allow her to make sense of her current situation and in so doing, she develops a stronger sense of her continuous self.

The Role of Childhood Family

Humans are relational beings and we interpret ourselves and our world by the connections and relationships we make with other people, the environment, and for some the spiritual dimension ¹⁹⁸.

To obtain meaning we need to see the connections between people and things around us, and it is in these relationships that a framework of meaning develops, which allows the person to locate their position within those connections. Family is the structure and process where a child comes to understand herself as a person, and relationships are the arena where she defines her identity. Families provide the narratives, the stories, the rituals and frameworks by which children see the connections

between events, people and the environment in which they live. The sexually abused child often lives in a family where the functioning schema is less than optimal. The violation of trust, the inculcation of shame and fear, and the absence of unconditional love, prevent effective development of self. The child does not experience her sense of worth, value, respect or personal power. Consequently she grows up with an identity grounded in shame and a diminished ability to protect her personal boundaries, respect and love herself, identify her needs, and express and move toward her hopes and aspirations.

It is in this family context that the child's sense of 'I' and 'me' are formed. The child has images drawn up in her mind about who she is, based on her family's responses and connections. It is these mind images or 'schema' that encourages her to undertake certain actions and activities. She will anticipate and imagine the response she will get from her actions. She will most probably choose the responses that confirm the picture she holds of herself. These pictures may have been skewed by the schema her perpetrator has seeded into her mind. Her actions are mediated by an internal dialogue of the different images she holds of herself, derived from her past. Her responses are arbitrated by the reactions she anticipates or receives from other people. Responses from primary groups, such as peers at school, friends and family are especially important. Taylor ¹⁸⁷ adds that moral orientation is a significant part of this process because people need to feel connected to what they see as 'good' within their relationships. This knowledge of what is 'good' is communicated in cultures via customs and rituals. Taylor uses the example of the family photo album as one custom by which the modern child is anchored in a family group, a community, a 'we'.

When I grew up, my Mum would dump me at my grandmother's place. She said she would come and pick me up and then she would never turn up. So they'd get angry, not necessarily with me, but the situation and I knew what was going on, so it still impacted on me sort of thing. I just felt like I was a pain to everyone. So I never wanted to worry anyone so I just wouldn't talk to anyone about anything.

My sister blamed me for something I didn't do and then she'd yell at me and she'd get the stepfather yelling at me. Whatever happened, it was my fault. I figured well, if I didn't do things wrong, and I was going to get into trouble for it anyway, I may as well do the wrong thing because I was going to get into trouble for it anyway.

I was starting to get boobs, but they wouldn't buy me a bra. I had these big huge things hanging half way down my stomach at 14 years of age, before I went to buy one for myself. By then every Tom, Dick and Harry was laughing at me and saying "You need to buy a bra".

I think what was wrong was they turned me against my family. They told me my grandparents didn't care. They stopped the visits. They stopped the letters. They never sent my letters. So I was basically very isolated for quite a few years. They wanted me to get rid of my photos. It was quite horrible actually. It took me ten years to find my grandparents again. To actually get the courage to ring up and find out they still did care.

Acknowledging and Naming the CSA

There are many social constraints that work together to keep CSA survivors silent. So it will help if the worker asks the woman questions that enable her to see how she has been kept silent so long. Questions we asked in this study included:

- What sorts of opinions about CSA in our society kept you from speaking out about your experiences?
- What might your family think if they knew you were talking about the CSA to me?

Such questions were followed by ones that shifted the conversation from a disclosing narrative to one that discussed the misuse of power that kept the woman silent. Examples from a transcript illustrate:

Interviewer: When you knew it was unsafe or unwise to speak out about the assault what enabled you to keep quiet?

Woman: I guess it was partially fear of what he could do to me, but it was more the concern for what he would do to my brother and my mother. He was a cruel bastard to my brother. He was always putting him down and I knew he would take his anger out on him, so I chose to keep quiet.

Interviewer: What might such a courageous and thought-through response say to you about your compassion and strength?

Woman: I never thought of myself as strong. I just wanted to stop him hurting my little brother who was already so vulnerable. I needed to protect him.

Interviewer: Does protecting a child and preventing them from being hurt by an out of control adult, fit with a story of strength or weakness, do you think?

Woman: I guess it was brave. I never thought of it like that. Hmm.... I guess I was strong!

I think of it as sort of like one of those 12 step groups where you actually admit what happened. That's what I see as acknowledging is. You stand up and say in a safe place, 'This happened'. I still have trouble saying it. I don't know if I could admit it in a group, what you're doing now with your life to try and help yourself is OK, but it is good to get the encouragement from people who have been through it. It's not so much hearing myself saying it, it's more I have trouble actually saying it. I have trouble actually getting it to come out of my mouth and say it happened. Even now I hardly ever say that it happened. Once you mouth those words it's like the full impact of hearing it hits you.

Remembering

Intrinsic to discovering self and making sense of change is the notion of power and control. As her worker you should seek to locate the various structures and narratives that sustain and augment such power to either promote or inhibit the woman's self-discovery. It is not always possible for her to step out of these structures and narratives because they are reinforced by the dominant culture. However, she may exercise control over their impact when she understands their influence and modus operandi. You can help her to narrate her retrieved memories through dialogical interaction, where she commences the meaning making construction that helps her to make sense of the present by examining her past life story. If you are empathic and compassionate the woman will feel safe to examine aspects and fragments of her memories and place them together to create a mind picture. Like 'puzzle pieces' she will begin to make sense of where she has been, who she was, where she wants to be, and who she wants to become. Some memories will be accessed easily and can be readily spoken about to the worker or group. Others are deep inside and not as easy to talk about. They are like bits and pieces of a complex jigsaw puzzle. Just as you start with the corners and side pieces in a jigsaw, the woman is encouraged to start with the stories she finds easiest to speak about. The woman may not be sure what the complete picture looks like, because she has lost or forgotten some pieces, but whatever she can connect will help the meaning-making and sense-making of her life story.

Memories are like puzzle pieces. You don't know how they fit together unless you look at each piece and see how it fits with other pieces to make the big picture.

Some women become concerned because they cannot remember clearly. They have actively suppressed traumatic memories, but this does not matter, because they can still use the 'Look, Think Act' process to heal. What is important is that they acknowledge that the sexual abuse happened.

Often fear of what will happen if the memories resurface, and concern by the woman about her capacity to control the flood of sadness that threatens to overwhelm her, will prevent her from undertaking the self-examination of 'Looking'. It will help if the woman receives some guidance in this process so she can locate a place to start looking back. For example, as her worker you can ask her stimulating questions that commence the storying process. Some examples from this study include:

Looking

- What facts can you recall of what went on in your childhood? (*I was always getting sores and ulcers in my mouth; I had wee infections all the time...*)
- What things can you remember? (*hiding under my bed; playing games of hide and seek around the house; hearing the bedroom door open in the dark, smelling alcohol on his breath, the pink pyjamas I had on...*)

Thinking

- What gaps are there in your memories? (*I can't remember anything between 4 and 10 years of age; I can't remember much at all about my childhood...*)
- Are there patterns in the memories? (*They always come back when we move into summer and it's swimming weather.*)
- When you see how the memories fit, is the picture of what went on becoming clear? (*I now remember it was a school swimming carnival when it first happened to me.*)

Actioning

- The woman should be encouraged to share these memories with someone she trusts.

This process should be undertaken with careful support because remembering can dredge up that 'package of feelings' linked to abuse and these can place the woman at risk. Thus the focus of your support must always be her safety. She may need time out, or she may need medication to help her deal with this time of acknowledging. When she is ready she will want to give a voice to her memories and feelings by speaking about them in the group, to a trusted friend, or to her worker.

The importance of this activity is not to obtain details of the woman's abuse experiences, nor is it to provide some form of psychoanalytic theory to those experiences. The object of 'Looking' is to allow the woman to give a voice to her experience and integrate her current situation with aspects of her past, so she can create a coherent sense of self that incorporates her new understandings and her chosen future responses. She can then put some closure to the past and recognise when its adverse reactions and responses are re-threatening the identity she wants to reclaim, or develop.

Recognising Disruption

The violating events of the past create a 'package of feelings' discussed in earlier chapters. They call into question the woman's sense of personhood and normality. Perhaps that 'package of feelings' has resurfaced because of current threats to the woman's reality. Disruption of reality makes the woman feel unsafe, threatened, anxious, disoriented, suspicious, and so confused she may have difficulty finding words to communicate her experience. Her heightened sense of otherness leads her to isolate herself from others, which impacts on her perspective of reality. Lack of knowledge about how to respond, adjust and recover, may contribute to her uncertainty. Creating a new reality requires the woman to relinquish some of her former ways of living. To do that she must acknowledge what is changing within that reality. The easiest way to do that is to ask her what is happening at the moment in her life, so she can begin to articulate her experience.

When her present reality is disrupted she must accommodate the changes. This accommodating process is often accompanied by a heightened sense of confusion, experiences of alienation, isolation, and otherness. Some women will ignore the disruptions because they feel so disempowered and don't know how to respond effectively. They choose to shut down and numb out the unpleasant feelings to minimise the discomfort that accompanies the disruption. She may choose to ignore the change or pretend it's not happening, because she is not sure what is happening. The woman needs to create new meaning, to begin to locate or maintain a coherent sense of self-identity.

For the transition process to occur the woman needs to acknowledge her reality is under threat and needs changing. You and/or the support group can help her to construct or surface a new reality through exploring her narrative. This process does rely on the woman believing her reality is open to modification and recreation. For many of the women in our group this was not a near enough possibility at the outset of our project. However, with time and the creation of a safe space to speak and be listened to, and the receipt of affirmation and encouragement, some women began to believe it was possible.

It can mean that for a time the woman examines her current patterns of living and being in the world and in examining where she is now she will surface ways she is creating, and has created, meaning. You as group facilitator and others in the group will reflect back to her the ways she can generate meaning through the conversations. This shifts the woman out of her taken-for-granted world so she is forced to see herself differently. She can then begin to reconstruct 'Who she is now'.

I find you sit there and you think about it and think about it and all these emotions and all these thoughts come in and it builds up and you just feel like exploding, but there's nobody there to explode to and you need to do something with that. I'm starting to look and think more... I noticed yesterday I thought about the needle twice. I thought about it and I know something is breaking down inside me and I am in trouble. I am aware now that something is breaking down in me when this thinking starts... if I stay connected and speak about it, that's how I will save my life.

Looking: What Is Going On?

Looking or observing is in effect the process of observing the setting or the situation, gathering information to define and describe what is happening, or what has happened in the woman's life. The question 'What is going on?' is asked. This type of question marks the beginning of a process of reflection, through which understanding emerges and actions for change can be implemented. Of course, women will offer different perspectives, reflective of who they are, their culture and their life experiences. As a starting point, this process requires the woman to become inquisitive about understanding the relationships and forces between circumstances, action and consequences in her life. Many CSA survivors are ambivalent about their lives so it helps to work from current situations backwards. They need to ask questions like 'Who am I now?' and 'What's happening in my life at present?' In narrative conversation, the woman will increase her self-knowledge, as she begins to understand the forces that shape her responses and begins to see from where her reactions are surfacing.

Observation, as a part of the reflective process, is about learning to understand the human situation and see ourselves with clarity. We try to construe meaning from experiences and situations in which we play a part. The idea is that we learn and make sense through dialogue. Chinn and Kramer¹⁹⁹ used the term 'personal knowing', which is 'an unfolding process that is grounded in the context of everyday experience, in relationship with others'¹⁹⁹. Strong facilitation skills are required to facilitate observation, but you do not need to be an expert. It is a learning process and as her worker or group facilitator, you can learn alongside the woman.

I didn't like what my friend was doing... the way he was acting and treating me all the time. I stopped and looked at what was going on and thought about it, and thought, 'I deserve better than this!' So last week I said "It's not working. Goodbye!" I told him it was time to start AA meetings, because he had a drinking problem. He disagreed saying, "I've got no problem". So I said "Well goodbye then, because I think you do have a problem, because at nine o'clock in the morning you are drinking and that means you have a problem!" I don't want to end up in a marriage with some guy who's a drunk, and a few years down the track I'm unhappy all the time and have three kids who I can't leave. Awful! No More! I saw through it this time...

The Worker's Self Examination

When we work with women, we are not unbiased. We bring personal values and prejudices to that work, thus we may 'see' what we choose to see. The most important implication of this is the need to make explicit our personal assumptions, values, and theories, and take into account our biases. Personal introspection and systematic reflection within a defined framework can help to keep such bias in check.

A woman who endures CSA or neglect from the family, that is a key source of self understanding, is denied the opportunity to develop a coherent sense of self. She may struggle to understand her place in the world, and the experience of nurturing relationships. As we discussed in earlier chapters the woman's capacity to trust herself and others, is affected by CSA. She may be suspicious, hyper-vigilant, sensitive and careful about what she says and how she speaks. Thus creating a milieu of trust and reciprocity is essential to effective work with these clients.

An example from the researcher's journal illustrates... I was deep in thought about a woman's response to the emotion of anger that she experienced in a relational situation, during one of our group meetings. I must have been staring quizzically in the direction of one of the women in the circle. She responded with angst 'Why are you looking at me like that?' I apologised saying 'I'm so sorry Y, I didn't mean to stare. I certainly wasn't deliberately directing my focus to you. I was just thinking about what X had said, and I was wondering what the anger was telling her about herself?' This interaction highlights the acute sensitivity of this client group and their heightened observation and close monitoring of presence, gestures, body language, and non-verbal communication, which they readily interpret as criticism toward them. They need to see your attentiveness and experience your non-judgemental attitude. They must see congruence and authenticity between your verbal communication and your non-verbal interactions. If they are unable to see that congruence, they are unlikely to disclose or interact, and their healing and growth will be adversely affected.

Questions About The Assumptions Each Person Brings

Do not assume you know what is happening for the woman. Instead let her give a voice and language to her experiences. In so doing note assumptions and ask simple questions so you are clear that you have the woman's perspective and not your own. Perhaps start by asking questions like 'What's happening now?' As a worker you may think 'That event must have made her angry.' Rather than assuming this, turn your assumption into a simple clarifying question to the woman, 'How

I can't look too far into the future, but I know that it's going to be better than what it ever was. When I was 17 I lived by myself, I had a beautiful house, I had all antique furniture, I worked, I had a Rotweiler, a cat, a car... you know? I know I'm capable of doing these things and I know how much I value these things and how quickly they can go. Just like that, if you're not up with it. So now I'm more prepared to think some things through, rather than act on impulse. ...reactions tend to be grounded in my past and when they are not very well thought through, they don't get me what I need, let alone what I want for the future. I know things are not that easily obtained, but they are oh so easily taken.

did that (whatever the experience was) make you feel?' 'What did it have you thinking or saying to yourself?' During the process of unpacking assumptions you reveal a lot about her taken-for-granted norms on the issue under scrutiny. You learn about the personal values and beliefs you both hold. In narrative work a re-authoring conversation asks questions that allows the client to focus on aspects she can use to re-story her future, it does not dwell on the traumatic episodes of her lived experience. It then explores aspects of the experiences that can be used to build a preferred story of identity from a variety of perspectives. At all times the woman's knowledge is sought and privileged in the conversation. Her ideas are honoured and her personal agency is highlighted. In these conversations the woman is looking into her experience and making meaning from that experience. The worker can note the filters through which the woman makes sense of her experiences. In asking simple questions the worker can facilitate the ongoing puzzling of what is happening, because this process surfaces options for the woman to reframe her

sense of self. As you discuss, either one on one, or in a group, you will expand her new identity by drawing out and building up the aspects of the self that demonstrate her strengths.

The Use of Metaphor to Make Sense of Disruption

We found the women used metaphors in their stories to underscore the emotional impact of disruption/s on their lives. Metaphors appear to add weight to the significance of the loss and discontinuity the disrupting events cause. Many women used them to express their distress and in so doing assist in making sense of the chaos and suffering that disruption has engendered. The metaphor gives the woman a framework to articulate the inexplicable into a picture, so others can comprehend the feelings and emotions attached to the experience. They allow a woman to locate alternative meanings that can facilitate reorganisation of her thinking so she can develop a coherent sense of self in the midst of chaos ¹⁸⁸. People use cultural discourses to create a relevant fit for their experience by linking the two with metaphors. This is a way of establishing coherence and continuity in their life experiences. These cultural notions are open to discussion and will often highlight the woman's underlying concerns. They may provide an opportunity to relocate the self blame that entraps so many women.

I suppose it is like picking up a big fruit salad and throwing it all over the floor. That was when I had nothing. And then picking up, oh, grapes, cherries, you know what I mean, like having the fruit spread out in front of me and then picking out the best bits, then deciding consciously to leave whatever I'd done wrong, because I know that was through circumstance beyond my control, or when I was out of control. But that is not how I am now ...I'm not a mean, nasty person and I believe that. A lot of that's to do with what's happened in this place, with this group.... It's just little bits here and there. I never wanted to be a person that needed to live in somebody's pocket, or rely on somebody else for my self esteem. I think what I've done wisely, is to take the little bits of wisdom that are the treasures and make myself again.

The Role of 'Guiding Metaphors' in Sense Making

Metaphors provide cultural congruence and they can become mind pictures that serve as a map to locate one's self in the dominant culture. A guiding metaphor may be described as a socially significant picture of a privileged concept within the dominant culture. Take for example the particularly important notion of family in western culture. It is viewed as the primary developer of moral values, cultural beliefs and social norms. It is a place where a child's identity is shaped and nurtured. It is viewed as the unit that provides love, nurture, shelter, food, education... to children. What of the woman who lived without these experiences as a child? Her guiding metaphor for family life and love has become confused by her perverse experiences of abuse, abandonment, sexual assault, blame, guilt, fear and shame. As she grows she feels increasingly different, she may feel betrayed and excluded socially as she recognises the lack of cultural fit between her reality and the broader social norms. Consequently, she will need to clarify meanings around this guiding metaphor in her life story if she is to decrease her sense of marginalisation in the community, and betrayal within the family.

In this study we discovered four common metaphors that women who have lived with ongoing disruption use to make sense of their life. These are best described using the women's words. The first, *'expect nothing and you won't be disappointed'*, is a view that enables the woman to lower her expectations of others so she does not experience the pain of ongoing rejection, betrayal and disappointment, when people do not meet up to her expectations. The second view, *'life's a bitch and then you die'*, proposes that the woman should resign herself to the fact this is as good as her life will get, so she should just try to make the most of it. It can lead to apathy and sustains notions of disempowerment and victimisation. The third metaphor is, *'What's normal anyway?'*. In this perspective the woman is empowered enough to reframe cultural norms and ignore aspects of them that do not fit her schema, or that she feels unable to fulfil. She does not conform to social norms so she may experience alienation or behave in ways that lead her to having 'brushes with the law'. The fourth metaphor is *'I will survive'*. In this view the woman is determined to fight and resist cultural norms.

Some discourses have such dominance and privilege within our culture that it requires sustained and determined effort to maintain a sense of social coherence when you cannot meet such socially prescribed norms. Family is one such notion. Families are defined firstly by biology, those who are genetically related and secondly by those who live in loving kinship relationships. The importance of unpacking these discourses cannot be understated, because the women express ongoing concern about their family of origin.

Several women in this study were placed in foster care, state care, or adoption programmes, therefore they associate rejection with notions of family. These women were then entrusted into the care of a surrogate family as dependent children and experienced sexual abuse within those 'family' units. This has reinforced understandings of family that are tied to notions of betrayal, abandonment, de-humanising objectification and untrustworthy relationships. Many of these women expressed concern at not knowing whether their birth mothers 'had to give them away', or 'chose to give them away', and this angst is replayed in a variety of ways as a metaphor of abandonment and rejection throughout their life. Some searched for a sense of continuity within a family of their own, having their own children. The guiding metaphors around family bonds have led some women to feel compelled to 'give up' their child/ren for adoption/fostering, because they felt unable to lovingly care for the child. Other women use the guiding metaphor as a cultural discourse against which they will fight. They have, and continue to, work hard at establishing and maintaining family bonds with their children. They note that having their own child/ren is 'their reason for living', their 'anchor point' of meaning and purpose in life.

Someone said to me that having a baby was like a miracle from God and that is exactly what I felt when my baby was born.

I adore my son and I love him with all my heart and soul... I am just so proud of him. He is so good to be with. He is very caring. He is funny. He brings me real joy.

My daughter is the apple of my eye, I only have one. She is 16. She is amazing. She is my reason for living.

As a worker you can help the woman explore her story and unpack the metaphors within that story. This will enable her to make meaning of her situation, both past and present, and re-establish a sense of coherent and continuous self in the midst of a life of ongoing disruption. The presenting disrupting experience/event calls into question the woman's sense of personhood and 'normality', shifting her out of her taken-for-granted world so that she sees herself as 'different'. In a nutshell, she needs to answer the question 'Who am I now?' You will be able to help her name what is happening at the

moment, and in this process locate important aspects of her disrupted sense of self that she can use to reclaim her shifting identity. The woman will usually want her life to display coherence between past, present and future... and disruption threatens that integrity. She may have a vision of how she would like her life to be and it will help her if you can give her the space to articulate this vision. She may see the need to make changes to aspects of her circumstances that don't fit her mind picture. You may need to help her locate immediate options that are available to her, so she has enough hope and motivation to continue to work at acknowledging and disclosing her past CSA story.

Conversations that unpack the cultural foundations of metaphors are best undertaken later on in ongoing conversations, the woman will describe her experience/s and the effect metaphors have had in binding her past and future together to give a sense of continuity. Such conversations explore the context of the current disruption and the way the woman has managed, or did not manage, to maintain her sense of self. In these later discussions you can examine notions of family, class, ethnicity, gender, social roles, status etc. These normalising ideologies are complex discourses that are socially reinforced and impact the woman's sense of self and her place in society. It can be liberating for the woman to see that her sense of 'otherness' is influenced by these discourses, that label her as 'homeless', 'abused', 'alcoholic', 'drug addict', 'gambler', 'dole bludger', 'prostitute' etc. In this process she can work at diminishing the adverse impacts of such discourses and refuse to allow them to distort her developing sense of identity.

The Therapeutic Milieu

The 'Look, Think, Act' process proposed here is not a specialised 'therapeutic' approach and does not require specialised training. You do not need to know exactly what things to say in order to make the client feel better. What is most important is that the client knows you are there and that you care. It is often remarkably simple what people need. They need you to be present, focussing your attention on them. They need to know you are open, genuinely attending, and willing to listen to them with your whole self, not leaving your heart and feelings locked in your professional kitbag. Equally, they need you to maintain emotional coherence and not get overwhelmed and unable to cope with their story.

In addition to your compassion, women need your neutrality. Many of the events that you hear about will elicit very strong emotions and feelings in you. You may feel angry, sad, grieving, frightened, horrified, shocked and deeply disturbed. It could be helpful to speak about some of these feelings, so that the woman you are working with realises that it is a normal to have such deep emotions. It also reminds her that it is okay to have and feel emotions. In our group we shed tears over stories that

we heard within the group and the women were moved and not offended by the tears. That is not to say that this is recommended, because it is important to stay in control of emotions, but it is also OK to experience them. For the most part, the goal of individual work is to help people identify and experience their emotions and locate their feelings. To do that they need a calm, grounded worker who is present, rather than overwhelmed with personal emotional reactions. You can provide the best healing environment by making sure your work is focused on her feelings, not yours, and that her issues occupy the time and space of the therapeutic relationship. It is most important for you to be present, without judgment, trusting in the woman's own healing process, and her and your personal knowledge and intuition.

Beginning to 'Look'

I sat down reading the feedback and I was thinking of the hate that I carry for my mother... it's unbelievable. I mean, when I really sit down and think about it, the humiliation she put me through, the not being there, everything – I blame her... the hate that I carry for her is unbelievable and I did not realise how much I hated her until I read the feedback. That's crippling me. It's almost scary to think that I can hate her so much for being my mother. I need to talk about that.

The disempowerment and disconnection bought on by CSA must be recognised if healing is to occur. Through the process of learning to 'look' around her, a woman may begin to desire to change long standing patterns that she sees as being a source of pain, and this may be why she has come to you.

Begin simply.

Introduce yourself; tell the woman that you are there to help and to listen. Do *not* begin with discussion of the traumatic events unless she initiates that discussion herself. Begin by helping the woman become comfortable. Ask her how she is doing at present. Ask her whether she would like your help and how she

would like help. Ask her whether she wants to talk to you and what she would like to talk about.

The goal in the beginning is to meet and set up an agreement and a space in which a therapeutic relationship can begin to develop.

Let the woman set the agenda.

Perhaps the simplest way to promote the journey toward healing is to trust the process. The woman will bring things up in her own way and her own time, as she becomes ready. This may mean times of silence, once initial greetings have taken place and you have let the woman know that she can talk about whatever she wants. Time may be needed for her to decide what she wants to talk about. Sometimes women need help to look at one particular area or issue in their life. Disrupted lives can be filled with confusion and assistance to focus can be a major first step.

Allow the narrative to flow.

Once the woman has begun to talk about what is important to her, engage with her, let her know you are interested and provide minimal encouragers to let her know you are hearing and interested in her story. This may require you to ask some questions. This is a matter of sound judgement and past experience. It is useful to remember that questions beginning with 'Why did you...' or 'Why didn't you...' are usually judgemental and are best avoided until you have a very well established therapeutic environment. Trust your own knowledge, intuition and instinct to provide simple questions and minimal encouragers. The initial engagement should be open for the woman to use to tell aspects of her story that she thinks are important to share with you.

Always work with permission.

Never coerce, pressure, or cajole a woman to remember or to feel. Ask if she would like to discuss something before leading further.

Create space and time for her to move into discussing more emotionally difficult material.

The aim of this process is to work with women to start the process of locating changes and disrupting events. You should note alternate plot lines within her story that highlight her strength and resistance. These plot lines should not be highlighted too early in the narrative process because they can make a woman feel as if the painful aspects of her story have not been heard, or that she cannot speak about them any more. It will help if the woman recognises the former disruptions and their impacts, noting what has changed in her life. She can then attempt to make sense of it, and integrate the changes into her life, so she can move on. Safe space and time is needed to do this exploration.

A common 'package of feelings' emerged in our study and were identified by all the women as grounded in their CSA experiences. This 'package of feelings' included fear, terror, horror, anger, rage, shock, grief, sadness, disgust, shame, blame, guilt, confusion. These are intense emotions and feelings that are culturally influenced. To manage the intensity of these emotions, the woman needs to learn to use the support of others. Being able to re-experience and express these feelings in the context of a trusting relationship can help her to overcome the mistrust, isolation, and damaged relationships of the past.

Help the woman recognise and develop her resources.

Women who have led disrupted lives following CSA sometimes find it hard to remember that their lives are more than the experience of CSA. The woman may want help to recognise her present capabilities, to draw connections between past abuse and present difficulties. She may need assistance to develop awareness that she is no longer the abused child and can draw on strengths that she may not recognise to deal with current suffering. There are opportunities to grow and flourish beyond the obstacles that beset people and it can be important for the woman to have her resources recognised.

Asking Questions that Facilitate 'Looking'

The woman will look for markers in the changing landscape to find her bearings. This is facilitated by asking questions such as 'What is changing?' 'How much has it changed?' 'What impacts are the changes having?' In this early phase of inner reorientation the types of changes we noted in this project were things like: loss of relationships, changes in home life, personal, work, finances, inner self, frameworks of understanding... In these discussions the worker can ask questions that facilitate new understandings of the woman's preferred self, helping her to separate herself from the problem. Some examples from transcripts include:

Unpacking the experience and its meaning

- What did that mean for you back then?
- What aspects of this experience do you think may have led you to see it that way?
- What is it that you know now, which you did not know at the time?
- What does that say about what you are hoping for yourself?

You seek to create continuity within important strengths in the story over time

- Can you tell me another example when you didn't run but stayed and faced the situation?
- Have there been other times when you felt that way?
- What do you think are the triggers behind these responses?

Externalising conversations seem to diminish the power the issue holds over the woman, even in a group conversation. The worker then searches within the conversation for things that say something about the woman's preferred self-identity, rather than keeping the focus on the 'problems', but this is discussed further in the next chapter on 'Thinking'. Remember that making meaning is a culturally mediated activity and the woman's preferred identity exists in a cultural context and these conversations are about opening possibilities for new understandings of self, so they should not be too restrictive.

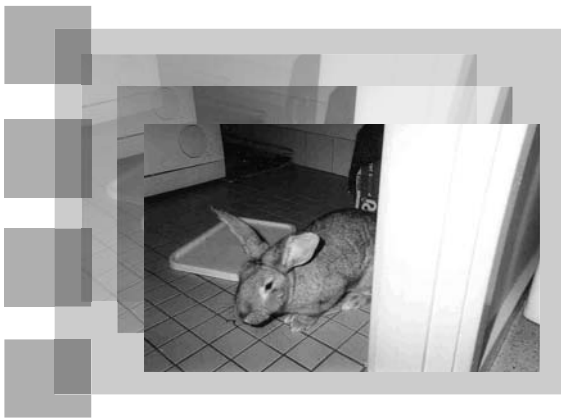
Summary

In this chapter we addressed how the therapeutic milieu facilitates 'Looking'. We expressed ways a woman can be encouraged to work out what is/has been disrupting her sense of self and the role that guiding metaphors play within that process. In the early conversations that are a part of the 'Looking' process questions are broadly aimed at helping the woman unpack her experiences to see what more she can see, feel and hear about the experience, in retelling her story aloud. Questions should be couched in ways that invite her to engage with her story, so she can begin to name what she is, or was, feeling and experiencing. You are reminded that the work of looking is not about reliving trauma. Looking involves the woman unpacking the impacts of her experiences to facilitate her capacity to make sense of these experiences in such a way that it helps her to reclaim her identity and shape her future.



Chapter 5

Making Sense of Impacts: Thinking



The impact of change, whether it has been chosen or forced, was the key reason the women in this study started seeking professional help. It was a combination of loss of autonomy, violence, addictions and homelessness that were the catalyst that brought them into our capacity building project. During the time within supported accommodation the women had the space, time, shelter, personal safety and support to begin the process of 'Looking and Thinking' about their disruptions so they could locate what had changed and what was ending.

Recognising What Has Changed

Change is a 'situational' event, a happening that occurs in one's life, whereas transition is the 'psychological' process of inner reorientation and self-redefinition that people go through to incorporate those changes into their lives ²⁰⁰. Transition starts with a natural process of disorientation

and the recognition that a process of reorientation is required. It marks a turning point that can be viewed as a threat or an opportunity once it is identified²⁰⁰. Being homeless is often a crisis situation and such cataclysmic change raises the necessity to ensure the woman's basic need for safety and shelter is met before the work of reorientation can commence. The woman has to recognise what has been disrupted and name the events and circumstances that she has experienced that have led her to this change. It will help her if she can order those events to make sense of what is happening. That requires looking at her current situation and issues, to give a voice to the pain of the disruption she is experiencing, or has experienced, when she is ready to do so.

Bridges²⁰⁰ notes that transition from a dependent child/adolescent to an independent adult has no rite of passage within our culture. As the child grows into an adolescent she experiments with different roles and relationships which form her identity. These experiences join to develop in the adult a coherent sense of self identity. He adds that if life tasks in any phase of development are incomplete the person can have 'unfinished business' and this may stall their ability to become independent until these aspects of self-identity are reclaimed and brought into the present²⁰⁰. Transition can reactivate identity crisis, as roles and relationships are changed and the person's ability to move forward with life is restricted until the changes are incorporated at a psychological level.

If the woman chooses the ending it may be less painful than if the ending is forced or imposed on her, but either way there is no going back to the way her life was. The life task at this time is to let go of the past, taking into account that she will need to grieve her losses, including the unexpected losses. The confusion of disruption may be clarified by the 'Looking and Thinking' process. You can help the woman to explore her story from the cultural metaphors that are used to bind her past and future together to give her a sense of continuity. This exploration reveals to her the current ways she copes with change and how these may have been militating against her self belief and her capacity to choose how she defines herself. It will help her if you can explore together how she was recruited into beliefs that children's rights are subjugated to adult's authority and how such socio-cultural values lend weight to the difficulty of breaking the silence about the abuse. Some service providers note the importance of looking at the varying power dimensions in a child-adult relationship, and in so doing highlighting the lack of influence a child has over an adult's behaviour. Such discussions lend themselves to exposing the tactics adults use to silence children and those the perpetrator/s use to silence the woman and recruit her into believing she is somehow to blame for what happened to her. Conversations can work through the contexts, constructions and words the perpetrator/s

I am not in my own realm. I'm out. There's nothing under my feet. It's hard to hold on to something when everything you are is different than it was...

use to diminish the sexual abuse as 'playing', 'tickling', 'mucking around', or 'training'. In so doing the stage is set for you to help the woman see she is not to blame and that her ways of handling the sexual assault as a child were part of this context.

These conversations highlight the power differentials that support emotions such as fear, shame, guilt and blame in the child, showing how these influence decision making. The dialogue provides opportunity to begin to shift the focus on alternative plot lines of courage, strength and resistance within the woman's story. You can examine the fear and how this correlates with the extent of courage that she needed to survive. Invite her to discuss how she coped with the emotions, exploring 'how fear may lead to compliance, but how compliance in no way equals consent' ²⁰¹. It is important to keep the focus on how the woman survived, in spite of terror, rather than focus on the traumatic events. The result of such externalising conversations is that the woman begins to separate herself from her emotions.

You may find that she will examine former patterns of reacting and responding, checking her earlier mindset and that this reactivates previous impulses and emotions and dredges up the 'package of feelings' relating to her abuse experiences. In our project the women began to see the part their responses and reactions played in their situation as they moved through adolescence and into adulthood. However, as Bridges (2004:15) reminds us, most people 'resist this understanding as if their life depended on it', so it takes time and ongoing therapeutic work to achieve that perspective ²⁰⁰.

Humans want their life to display coherence between past, present and future, and disruption threatens that integrity and continuity. They have a mind picture of how life should be and changes can mean that nothing fits the woman's picture of how she wants to live, or thinks her life should be. If the woman can be facilitated to come back to her life in a new way and locate what has ended, she may be able to let go of the 'old' and pick up aspects of herself to create new ways of living in the changed circumstances. It's not easy work and there will probably be parts of the woman that resist acknowledging and exploring what has ended because of the pain it causes, and her desire to stay with what she knows. It can help the woman to look back at how she faced disruption and change in her past. However, many women find the concept of looking back at past disruption a vague and nebulous activity. In this study we found it more helpful for women to start working with situations in the here and now.

Asking Questions: Starting the Sense-Making Aspect of 'Thinking'

Needless to say the aspects of 'Looking' and 'Thinking' may not be as obvious or sequential as it would seem when documenting this process. There is a continual feedback loop within one's head and it is usually moving back and forth all the time and sometimes very quickly. These two concepts are deliberately separated in this text so you can see how to facilitate each aspect within your work with women, but they are not as readily separated in practice.

The key function of 'Thinking' is to extend understanding and work out what the situation/issue means. Checking out the values and taken-for-granted assumptions behind information will help the woman to work out what she should challenge and what changes she may need to action to reclaim her preferred identity. She will explore questions like 'How did I come to be here?', 'What sort of things are being challenged in me and why?' In 'Looking' you ask questions that allow the woman to gain a near definition and description of what is going on so she can gather information about what is happening. In 'Looking' the key question supporting identity is 'Who am I now?' In 'Thinking' you ask interpretive questions such as what, how, when and where questions, so you both gain an understanding of concepts, themes, influences, problems and their antecedents and consequences ¹⁹⁷. (Note: It is safer to avoid 'why' questions, as they may be interpreted as judgemental by the woman). In 'Thinking' the woman is working out why things are as they are. In 'Thinking' the key question supporting identity is 'Who am I now with... (naming the issue)...?' The tasks of 'Thinking' can be described as deconstructing what happened, interpreting the issues, making sense of information, confronting and challenging personal and societal assumptions about self and the 'problem/issue'.

During this project, information was clarified in the group, and the facilitator identified key elements of the experience from the verbatim transcripts of the group meeting. These themes were categorised and fed back to the women for them to consider what actions they wanted to take. In 'Actioning' the woman reconstructs her story and actions different responses that solve problems or initiates movement toward her preferred identity. She will then commence the 'cycle' by looking at what happened, evaluating the outcomes of her actions to see if they were effective, or not, in moving her toward her desired goal.

I feel I've done nothing that is too late to change, or too late to repair. What has made me better with my children, is thinking about what my mother and father were to me. It increased my determination to make my children's lives different no matter what. Even if I did fall down, even if I did stuff up badly... I've been to jail and my brother has come to look after my kids while I was in jail. My kids have had to come and see me in that jail. I've shown them with my own life that there are consequences. It's just a good thing that they have a spirit and mind that is willing to see that and not hold that against me. My son did for a while, but we have been working through that. It's not an instant repair.

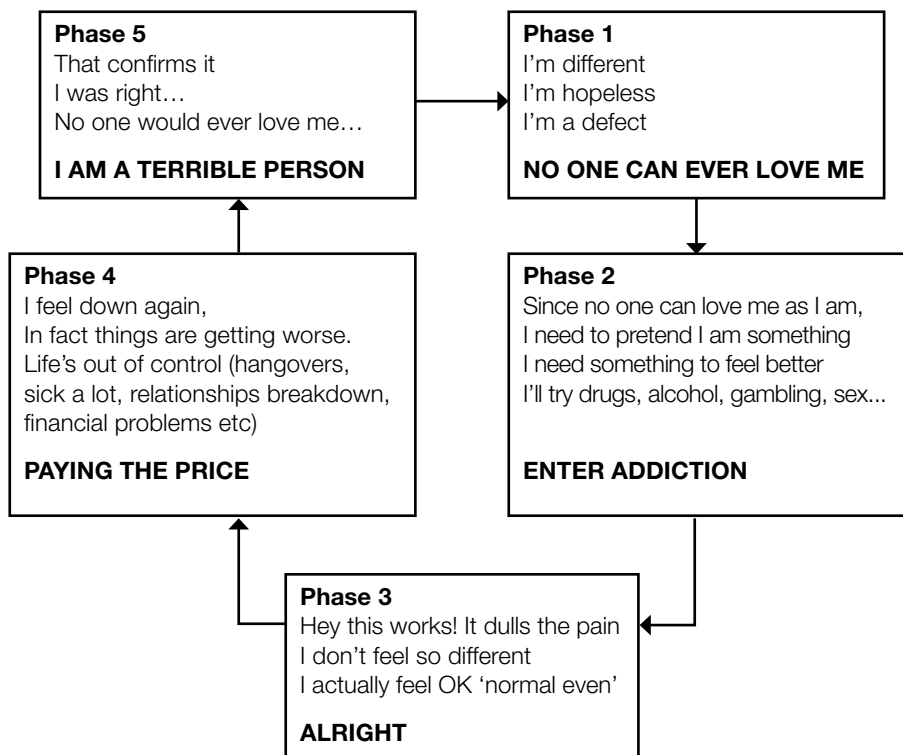
I realise it's not too late to turn it around, if I want to. What I have said to them in the last couple of years that we've all been back together is, that we're working it out together now. They sit and we talk about it. They tell me they see how it was and we discuss where I was, and where I am now. They are happy and proud of how far I've come.

Exploring the Shame-Based Identity

You can facilitate exploratory thinking by asking questions that help the woman to unpack her story and locate meaning in aspects of her narrative. All of the women in our group experienced self-abuse and risky self-destructive behaviours either in the present, or in the not too distant past, and this behaviour actively contributes to their homelessness. White ² says he believes that these behaviours are an expression of childhood abuse the person was subject to, and we would agree. These self-destructive actions have been shaped by meanings that the woman has assigned to her sexual abuse. These meanings are expressed in perspectives of unworthiness, blame, deserving what she receives, or at fault for not stopping the CSA from happening to herself and/or others. Consequently, her life is scripted to behave in ways that confirm that perspective of unworthiness and self-loathing. This is illustrated in the cycle of shame developed by Tucker-Ladd ²⁰², which demonstrates how the cycle of shame fuels blame and culpability within the woman.

Figure 5.1 The Cycle of Shame

(Based on the work of Tucker-Ladd ²⁰²)



Using Narrative Questions to Disempower Blame and Shame

It is the stories each woman has about herself and her life experiences that provides the lens through which she sees herself and the frameworks by which she understands her world. Surfacing these diminishing constructions of the woman's self and the structures that are present in her life that support such perspectives is the work of the group, or the worker. Through dialogue the woman can start to see positive aspects of herself and locate counter plot lines within her life story that demonstrates resilience, strength, resistance, success and love. Your aim as her worker is to help her to see this new view of herself, so she can choose to action ways to express herself that are in keeping with her developing affirmative life script.

Before negative thoughts were consuming me... it was eating away the opportunities I could see, and stopping my progress. Now I see opportunities. I can see a lot more clearly now, because I'm not immersed in my own guilt, shames, sadness and sorrow. I'm looking around me, not within me all the time.

The group provides a collaborative process to generate this new mind picture which is reinforced and reflected to the woman within group interactions. The group gives a forum to testify to those experiences without revisiting their traumatic aspects, so the experiences are recognised and validated as real, painful and unjust. Each woman comes to see she is more than her abuse story and its accompanying 'package of feelings'. It's important that she does not feel as if she has to go back to her past abuse experiences to move on. In the telling of her current narrative

she is able to isolate special knowledge and skills she has developed to survive her past abuse experiences. Our group reviewed their addiction as one strategy that enabled them to traverse the darkest days of their lives, but it became a problem that added other unanticipated difficulties to life. In this thinking phase you should encourage the woman to recognise that actions she chooses to advance her sense of self are not selfish, but constructive and positive. The woman must feel that her story is honoured and that the opportunity to express it is available to her. These conversations can be distressing but should not be traumatising². The aim is to surface the knowledge and strategies she can draw on to understand how the voices of abuse have led her into false beliefs about who she is, and how she should view and treat herself. When you ask externalising questions such as those detailed below, the woman's looking and thinking is facilitated by the deconstructing discussions her answers provide. There are good examples of other projects that use similar approaches in a group work guide by Linnell and Cora²⁰³. Some examples of questions used in this study include:

Questions that help the woman unpack meaning from events/issues

- What was the most valuable thing you learnt from that?
- What principles that you live by are you highlighting when you do that?
- What makes that so important for you?

Questions that promote exploration of the counter plot line of resistance and strength in the woman's story

It helps the woman to give her issues a name. You can then ask questions about her story that help her to see how she feels when the sexual abuse 'package of feelings' is more dominant and perhaps even 'in charge' of her choices. The type of questions to ask are ones that invite the woman to reflect on the different ways she experiences herself when aspects of her preferred identity are in the foreground. Then compare these to how she feels and responds when the 'package of feelings' of abuse are allowed to dominate the foreground of her mind. In this process you are aiming to help the woman verbalise alternative plot lines of resistance and strength within her story. You should listen and ask questions that help the woman discover this alternative story and ascertain how important it is to her. How might it be used to reclaim the sense of self she prefers?

Questions that help the woman examine her story from other perspectives

It will help the woman to separate herself from the disempowering plot lines and gain a more multi-dimensional view of her options if she can view her story from several vantage points. For example when she was a child, her school teacher may have viewed the situation of her experiences from a different time and set of social values. Questions like these were used to surface stronger plotlines of self from the feelings and experiences:

- What do you think your teacher saw in you when she said that?
- What might it tell you about yourself if your teacher saw you as gifted in that way?
- If you were another child in the swimming pool, what would you have noticed about that little girl when you saw what was happening to her?
- What would you learn if you were watching what was happening from outside the house through a window? How would it have looked to you?
- Imagining yourself as your mother, what would you have appreciated about yourself as a child?
- What helpful parenting qualities would you be experiencing if you had the opportunity to be your own parent?

These later questions challenge the way the woman has been recruited into believing she was to blame and worthless by the experiences she endured as a child. Remember, the woman's identity is effected by how others see her and interact with her and parents are vital to identity formation in childhood. Therefore abusive or unsupportive parents are key players in adversely shaping their child's identity. In answering the type of question noted above White ² notes the woman has the opportunity to experience the same compassion for herself that she can generate for others.

You have demonstrated to her that you love her and you are willing to stick with that relationship no matter what it costs. You have demonstrated lots of strength to her. Look at the times you could have walked away and you didn't. What your daughter says is something you must hang on to, it's true. You need to keep reminding yourself of what she said. Hang on to that because it's the storyline that says you are able.

Questions that highlight plot lines of resistance and protest

Below are a few questions used to highlight behaviours that were able to be viewed as interpretations of resistance and protest, resilience and courage. A woman gave her story of rebellious behaviour as an adolescent which had her in frequent trouble with the law. The perpetrator of her sexual abuse was her father and he was a police officer. During interview she was asked:

- So do you think the fact your father was a policeman may have contributed to your desire to not follow rules?
- Could your rebellious reactions perhaps be viewed as a form of protest about what he was doing to you?
- Does this reaction fit with a story of blame, or could it also fit with a story of protest and resistance?

The point of this blend of closed and open-ended questions is to make available to the woman alternative ways of thinking about her story that are less disempowering and highlight her strengths.

Questions that help the woman to give a problem an externalising definition

It will help if you give the current issue/problem a name, and then start to explore this with the woman to build a thicker description. Then using her description, encourage her to rename the problem in such a way that it is externalised from her.

Questions that explore the effects of the 'problem/issue'

It is then time to explore the effects of the 'problem' in the life of the woman and see what makes the problem more or less powerful in its impact on her life. For example:

- If I were the fear how would I know when to arrive?
- What things are going on that open the door to the anxiety?
- If the stress is waiting for the right opportunity to come in how would it know the time has come?

Questions that explore current problems with a focus on the woman's responses

It is true that many women who have been sexually abused in childhood can become quite detached from their experiences. It will help if you ask the woman to think of herself as experiencing the 'problem' situation. The process of asking questions can help the woman to step into her experiences in a more complete way so she can work out how to respond. The types of questions to ask could include:

- What is your attention focused on within this experience (name it)?
- What is unusual about this? How is it different from other times?
- What feelings are you experiencing as you are focussing?

- What mood would you describe yourself in as you think about this?
- What are you noticing as you think about this situation?
- Why is it worth noticing?

The abuse story is an alienating and demoralising story that can play on the woman's mind on a daily basis. It builds anger and this energy needs to go somewhere or it will get turned inward by the former life script of culpability, blame and shame and render the woman powerless. If the anger can be reinterpreted as outrage, the energy can be channelled into something that promotes identity. The companion book *'Reclaiming Myself After Child Sexual Abuse'* highlights many ways the women have nurtured themselves through times when the anger has resurfaced.

Some Examples of 'Issues' a Woman Survivor of Child Sexual Abuse May Wish to Explore Over Time

The agenda of narrative conversations, either one to one, or in the group, should be set by the woman, or the group. It will be helpful if you facilitate the discussion by having some thoughts or themes to explore, should the women not know where they want to begin. The following issues are some of the topics our group discussed over the 18 months of meeting together:

- Acknowledging the sexual abuse happened.
- How the woman handles memories, dreams and flashbacks.
- Her experiences of disclosing the sexual abuse.
- Her feelings about the offender/s or perpetrator/s and their behaviour.
- The physiological effects of sexual stimulation and how these contribute to self blame. For example the child may have derived pleasure from the physical touching of her body and she may feel this pleasure means she enjoyed it, thus she must be to blame somehow.
- The confusion she feels about her feelings about the perpetrator. Eg She may hate his actions but love the man; she may despise the person so much, that she hates all men.
- The medical discourses that place sexual abuse experiences as pathology and the woman as damaged, are disabling. These discourses render the woman as powerless about her capacity to reclaim and reshape her identity after such toxic human interactions. They may also absolve her of responsibility she should own for her own actions and interactions as an adult. For example one woman was labelled as very depressed with a conduct disorder. With conversations she was able to make sense of these diagnostic labels by seeing that the anger she experienced about her sexual assault had been channelled inside her through thoughts of self-blame and

culpability discourses that reinforced self-deprecating thinking. She was able to shift out of this paradigm when an alternative construction was made available to her and she could see she was not at fault and she began to direct her outrage more appropriately into creative collages. It is important to have conversations about labelling, especially within medical discourses which pathologise the woman's experiences. You need to focus on how these can lead a woman to abdicate responsibility for her healing, believing she has reduced personal agency.

- Recognising the impacts of sexual abuse on relationships, trust, sex and intimacy, parenting, sleeping, health, anxiety, phobias, self harm, sabotaging recovery, eating disorders, spiritual issues etc.
- Debunking the myths that lead woman to believe 'self-fulfilling prophecies' like 'If you have been sexually abused you will become an abuser'; 'You are predisposed to deviant behaviour'; 'You are powerless to control your sexual behaviour because you are a damaged person'. Such thinking needs to be challenged. Firstly, explore whether or not the woman thinks she may have acted in sexually abusive ways and then how she has come to believe these messages. Conversations should ensue that allow the woman to situate herself as either for, or against sexual abuse. If she situates herself against the sexual abuse then seek to find aspects of her story where that position was evident. These are very delicate exchanges and best undertaken in one to one conversation. [NB If the woman reports that she has sexually abused another person, you would need to refer her to appropriate counselling services and you would need to be aware of your legal responsibilities under the mandatory reporting obligations.]
- Social understandings of some of these impacts such as social constructions of love, romance, parenting, motherhood, family, mother blame, gendered roles, values frameworks for living, spirituality, morality, hope etc.
- Past ways of coping: What helped? What hindered? Addictions and their effects.
- Ways the woman could become more in tune with the voices of her body, mind and spirit. Check how these fit with the voices of the society in which she lives.
- Help her understand how her mind controls her responses. Explain how she may have more control over her mind by exercising her freewill to choose her responses whenever she is able to.

In the narrative process it is important that you help the woman to see how she interprets the events of her past so she makes sense of her personal world. This provides the framework for her to understand major life events and everyday experiences. In this process she will find it helpful if she can name her losses. You can explore the social constructions around lifestyle, family, roles and status with her. Some of the women in this study said they felt isolated and different from the rest of society, because they were not able to participate in the same way that others did within the community. This was particularly so in such roles as being a child, a girlfriend, a virgin etc. These

losses are important to acknowledge, discuss and explore because they highlight the woman's guiding metaphors, which can be deconstructed and understood so they can be challenged. It is important that you allow the woman or the group to assign personal meaning to their life events and the roles that accompany them. This helps the woman acknowledge and grieve her losses. It is important to her that you recognise her losses.

Many survivors are not in touch with their emotions and feelings, and experiencing and naming feelings is an important step toward managing them. Getting in touch with feelings can be scary and the woman will most probably need support in that process if she has become dissociated from the years of abuse. If we leave these emotions unsupported they can trigger the 'package of feelings' related to the CSA which in turn can cascade the woman into the suffering that leads her to use alcohol, drugs, substances or gambling to numb the pain of her loss away. The healing process is facilitated by helping the woman recognise when she is becoming overwhelmed so she can work with you to think of new ways to respond to those feelings, instead of isolating, or turning to past addictive responses. In this group the women found that the urge to isolate has to be resisted if the woman is to stay away from her addictive patterns of reacting.

Over time the woman recognises that she needs to reach out to trusted support people for help such as sponsors, friends, a support group, worker etc. so she can garner support and affirmation and reassure herself that she will get through this experience. One woman notes that at the times when emotions or situations feel overwhelming, she prefers to dissociate or isolate, withdrawing into herself. She is confused by her situation and cannot work out what is going on, so it is easier to withdraw. This turning inward can quickly slip into despair, so it is important that the woman maintains affirming relational connections in the midst of chaos. You may have reframing conversations about how change brings possibilities to find new ways of living and being in the world. It can provide opportunities to develop the identity the woman prefers. The woman can spend time 'Looking' and 'Thinking' about how she can achieve her desires. Then she must set about actioning the things that might make her choices happen.

As facilitator you should listen for the personal strengths in the woman's story and possible opportunities that she can use. This will increase her sense of personal agency and provide much needed motivation to do the hard work of reclaiming her identity. It will help her find reason and resources for the hard work of reconstituting herself. If you demonstrate a nurturing concern for her and compassion for her situation, she will find it easier to do this work. The women in this study found connectedness in the group and sustenance in sharing a common story. They cared for each other, recognising that no one could solve another person's problems but they could encourage each other to solve their own problems. This support was unsolicited, so the women felt able to do the

work required to turn up each fortnight and continue the sense making journey. Your role as worker is to facilitate the compassionate space to do this exploration, and nurture an environment of mutual support and active listening. You should maintain a sense of hopefulness throughout this work. We found that it is very important for the woman to know that you believe it is possible for her to gain a stronger sense of self and develop her relationships. Your belief in her, motivates the woman to believe her life script can be rewritten.

Identity and Transition

The process of reclaiming a sense of identity can take time. In this study the women began to explore the processes that were keeping them in unhealthy relationships and diminishing their sense of self. Their identity has been shaped by abuse and this led them into intimate partner relationships that were peppered with violence, ongoing manipulation and abuse in many forms. We found these responses were born from thinking 'this is all I deserve' or 'that's what I thought I was worth' and these are the voices of abuse. When the woman begins to recognise from where these voices come and when the accompanying 'package of feelings' they engender arise, she is more able to recognise how her current responses are linked to her past experiences. She can see that these responses are keeping her in relationships that trigger reactions that lead to misuse of drugs, alcohol and gambling. She starts to see that to reclaim herself she has to systematically cut her ties to the shame based identity, and gently but firmly, shore up the foundation on which her reshaped identity can be constructed. This is not done quickly, because the shame based identity was imposed over such a long time and often has been reinforced by other key relationships. The woman may be so used to being controlled at every level, having her story discounted and her identity diminished, that she feels she has nothing to say about herself that is of significance to the worker or the group.

To leave such relationships a woman requires enough confidence in herself to believe she can make it alone. She must have the courage to leave a known and predictable social group and step out into a future without shelter, money, employment, while she does battle with emotions such as fear, guilt and sadness. She may also have to deal with ongoing threats from her partner. She may think 'At least I knew what was going on then and I knew what to expect'. Her identity was imposed, predictable and dependent on her intimate partner. Leaving the relationship threatens to strip her of that identity and its concomitant roles and status as partner, lover, married, wife etc. These roles end with the relationship and she moves to what van Gennep²⁰⁴ terms a 'liminal period', or as Turner²⁰⁵ describes it, an 'in between' time, a 'limbo' place¹⁸⁸. In limbo the situation as she knows it has ended and she must leave one place, but she has not yet arrived at her preferred new place. White² terms this a 'migration of identity' between the point of separation and the point of arrival at

the favoured location in life, where her chosen identity is incorporated into who she is now. It is in this limbo period that the woman is most vulnerable. In this project we heard many comments that indicated the woman felt 'disoriented', 'confused', saying she felt like she was 'going crazy', 'spaced out', 'fuzzy', 'zoned', uncertain about where she was going and what she should do. How could she live when she was unable to recognise familiar landmarks in her changing interpersonal and internal landscape? She struggled to locate known signposts to work out who she was in the midst of all the changes. Many women despair at this point noting their frustration at who they have become, feeling 'even more useless', 'even less able to cope', or 'a failure'. The woman can become very desperate and she may return to the abusive relationship. It is all she has known and she says things like 'at least I know what to expect', 'he can be quite nice sometimes'. To live with so much change and uncertainty, while incorporating those changes into a new way of living and being, is facilitated when a woman has quality support.

I was feeling nervous and sick all the time, waking up every two hours. Transition is scary... I'm thinking, what's expected of me here, you know. Will they let me stay here? Am I doing the right thing? Am I the type of person they want here? In the end, I thought well, you know what... let the chips fall!

I remember feeling like that too, that new way of living... you don't know what to expect... do I want to stay here where I know it, or do I want to go forward with the fear that brings. You have the new scares and the new excitements and that sort of thing... It was simpler back there... but was it better? No! I only think it was, because I knew what to expect...

Figure 5.2 is a tool that workers can use with women to help them graph their transition so that they can see their shifting identity and patterns of living over time. It is adapted with permission from the work of Michael White ² and allows the woman to graph her sense of wellbeing on the vertical scale with 10 above the neutral point of 0 being excellent and 10 below the neutral point of 0 being deep despair. In doing this she will note that transition is not always straightforward, but has highs and lows, good days and bad days. Over time she will incorporate changes and develop new understandings of her experiences and transition will become evident. Seeing this movement can bring hope and motivation to keep her working toward her healing. It will highlight when she needs to seek extra support if her healing and recovery appear to be stalling below the neutral point for too long.

You can use this chart with a woman when she is planning change. She can chart her sense of wellbeing for the weeks or months before she plans to make the change, which is located at point 0 on the horizontal scale. The time before the 'Change' is called 'Pre-Ending' where she plots her sense of wellbeing in the months before the change event/experience occurs. The 'Limbo' period is the time after the change when she may feel empty, confused, disoriented, insecure, and numb.

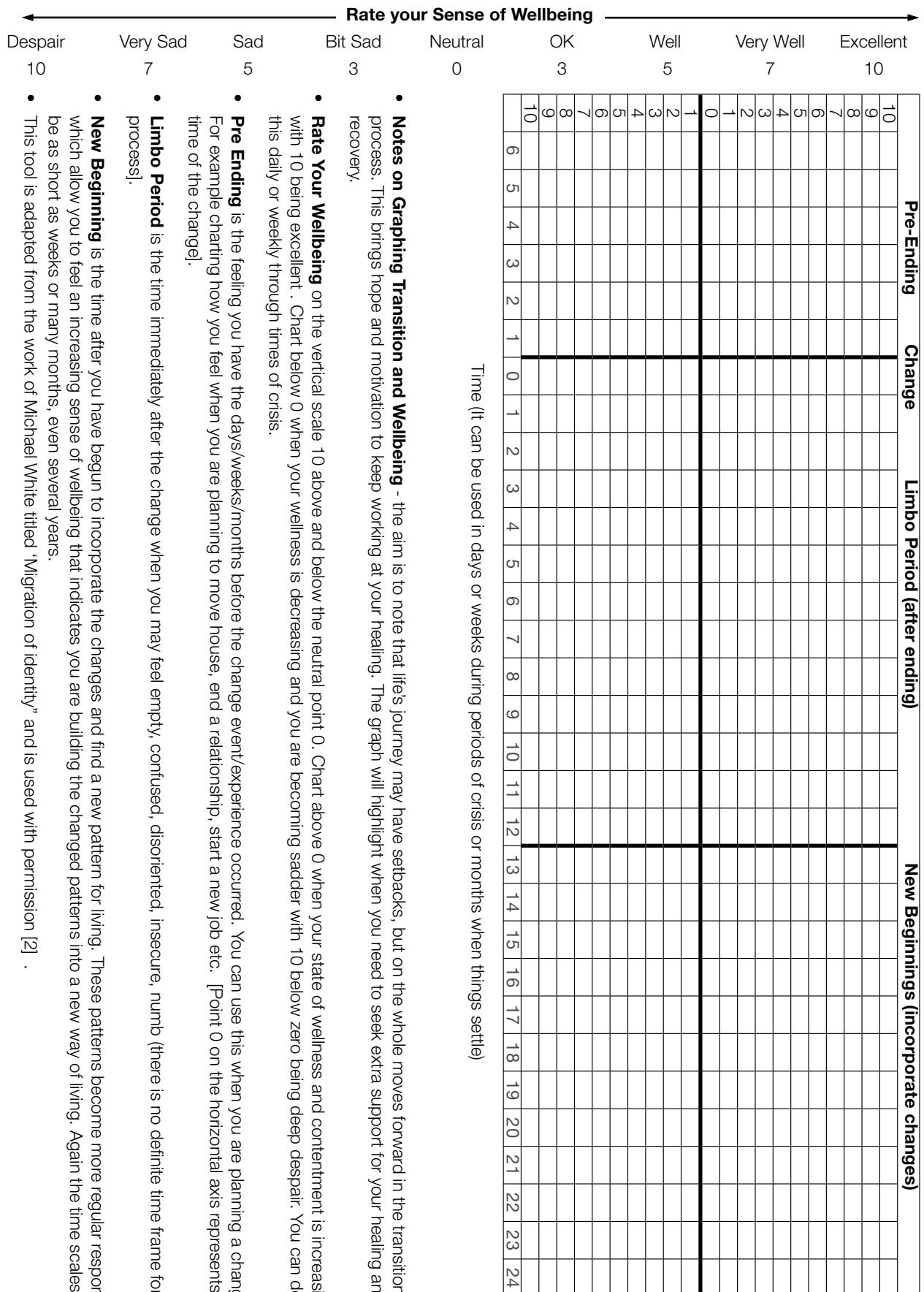
This can be shorter or longer than 12 months as there is no definite time frame for this process, but general wisdom is that it takes between 9-24 months timeframe to incorporate major life changes into a new sense of identity. The area titled '*New Beginning*' is the time after the woman has shifted into her new ways of living and responding and these patterns are becoming more familiar responses that promote her sense of wellbeing, indicating she has incorporated the changes into her life. Again the time scales can be as short as weeks or many more months. So we suggest the woman keeps the graph going for as long as she needs to.

White (1995:101) says he has several sample graphs that he shows the woman so she can see how the 'migration of identity' journey moves for most women. He says 'This is where Jane was at the three week mark. You are three weeks into this. Where do you think you are on the graph?' He then invites the woman to locate a cross on the graph where she sees herself now. He says this shifts the woman's despair at her disorientation and confusion into a more hopeful perspective as she sees she is moving on her trajectory toward healing. White adds 'Interpretations of regress dissolve, and hope, an antidote to despair, resurfaces...' It will help the worker to keep a copy of this work on file so the woman has a tangible record of her progress over time. It will help to show the woman this feeling that she terms as desperate failure, is in fact progress toward her healing. It may provide the internal motivation she needs to stay with her discomfort through the limbo stages of transition²⁰⁰. The woman can look forward to less pain and more clarity well before she has incorporated the change and made the transition to a new way of living and being in the world.

Summary

In this chapter we explored the 'Thinking' aspect of the 'Look, Think, Act' process, which allows a woman to unpack her story and make sense of the changes and disrupting influences. In the conversations and narrative questioning with her worker she is enabled to name her losses, grieve them and find aspects of herself in the plotlines that reinforce an alternative understanding of her sense of self, that more closely aligns with her preferred identity.

Figure 5.2 Monitoring Your Feelings in the Transition Process



Chapter 6

Reclaiming Self: Actioning Transition



Living involves transition. For many women who were sexually abused in childhood their life has been disordered and chaotic since childhood. Situations shift continually and changes have to be accommodated even when the woman has no control over those changes. Old ways of living can come to abrupt ends and new ways of living have to be created which cause great internal disturbance and turmoil. The woman can spend time in an indeterminate space we term 'limbo', where she cannot go back to the familiar and predictable way life was, neither can she work out how to live and be herself with the changes that have entered her life.

For some women the pace and persistence of change has meant they have never known familiar landscape markers and identifiers that help them know where they are, who they are, and how they should live and be in the world. The woman can deny the changes have happened or ignore the fact that familiar landscape markers have shifted, but eventually she must adapt and incorporate the changes or she will experience the consequences of not changing. These can include social

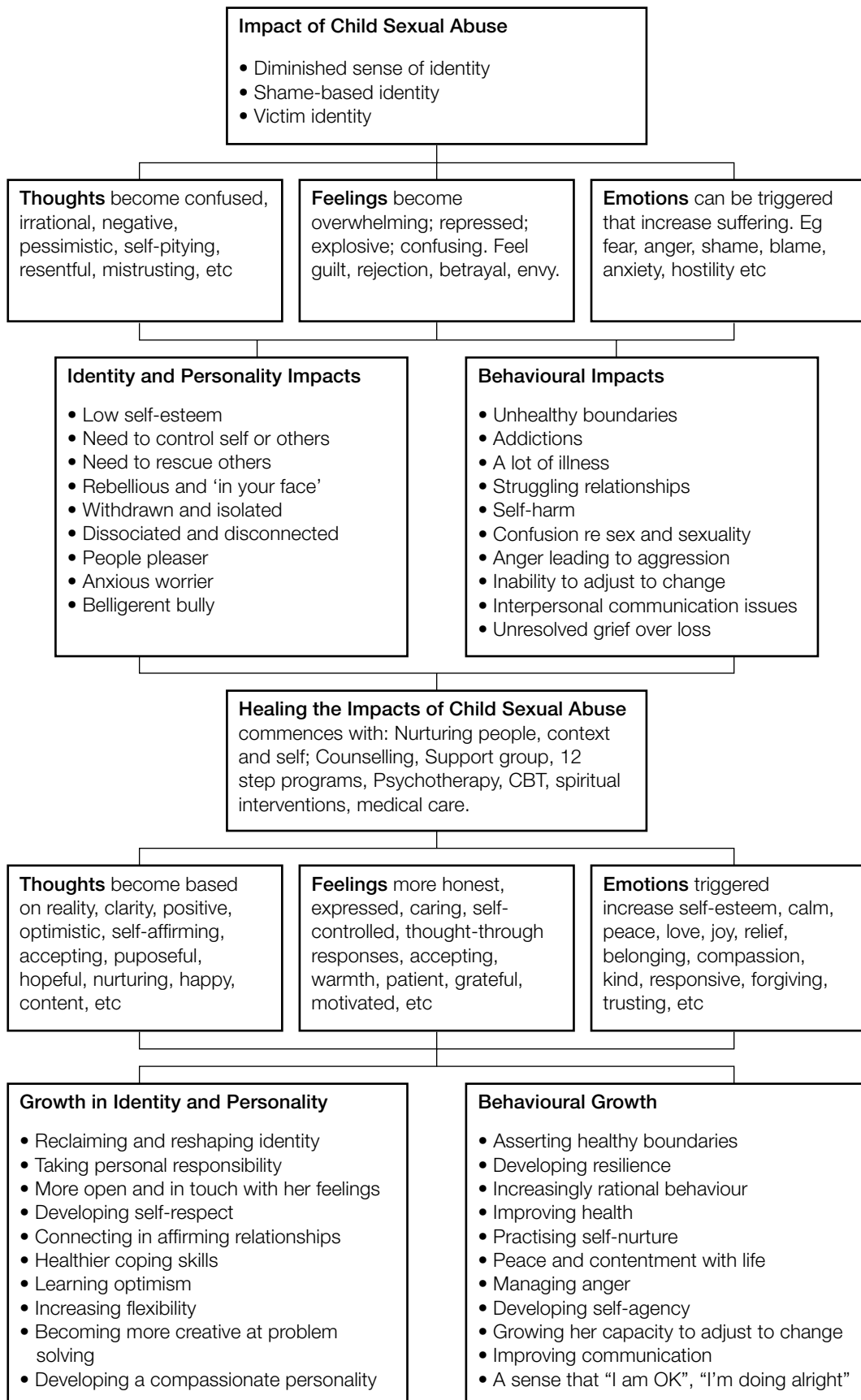
exclusion, illness, confusion, or feeling like she is going crazy. Changes can be chosen or forced, and they can bring exciting opportunities, or tragic and irretrievable losses, and any state in between.

No rules, I'm not used to it. I've always been told what to do... I know the opposite of everything you are supposed to do... now I have the freedom to do what I really want... and it's like I can't anymore... it's got to get to a comfortable level this conformity, because it can get really uncomfortable, and that's torture.

The process of looking, thinking and actioning allows the woman to seize the opportunities that changes may provide. She may begin to see some opportunities to reclaim her sense of self and reshape her identity into the self she wants to become, so she feels OK about herself. In looking and thinking the woman determines what aspects of the change she wants to work with, to create new meaning and understanding of herself. She plans how she can achieve her preferred situation or self and then sets about actioning the things that will make those plans

come into being. Figure 6.1 features some key areas of impact of CSA. These can be influenced by a therapeutic relationship that helps the woman to transition through these disruptions, by actioning new ways of living and being. These will enable her to experience a sense of normality, where everyday life starts to assume a degree of ordinariness.

Figure 6.1 Healing Some Key Impacts of Child Sexual Abuse



So What is Transition?

We have come to understand transition to be a process which can be a convoluted passage during which the woman redefines her sense of self and redevelops self agency in response to various disruptive life events. When undertaking the work of reclaiming her sense of self, each woman must come to an understanding of what has changed in her life and how her current reality is different. The women in this study made continual reference to feeling different throughout childhood and into adulthood. They have grown up feeling as if they did not belong. The shame-based identity many women have developed after being sexually abused during childhood fuels this sense of difference.

I've changed, got better, but I'm still going around in circles, right... I've been moving forward, and I feel like I've gone through the tunnel and I'm out the other side, but I have been squeezed to the point where I can't be squeezed any more. I have to move forward, I cannot go back, but it's hard work...

The woman is able to examine the nature of the change and the possibility, or otherwise, of returning to her familiar life. She can investigate how long this change is likely to be present and if life may be permanently altered. She may need to have help to see the possible trajectories that the changes are opening up. This exploratory process allows you, the service provider, to highlight opportunities and diminish the threats posed by the change experience. Together you can explore the significance and difficulty of the changes and the personal, familial and social

influences that are impacted by, or impacting on, the change. Once highlighted the woman can feel and grieve the losses that the changes have incurred. It can be a time of great emotional turmoil, stress and confusion, where even simple tasks may become overwhelming.

This process takes time as the woman disengages with what was known and familiar, and faces an altered and uncharted landscape, in which she must find a new place to locate herself. You can facilitate this process by providing a safe space to listen to the woman's story so she can hear her own words and explore new perspectives on that story. In the dialogue she will surface those values she holds and perspectives of herself that she wishes to reclaim, and those she wants to discard.

Without such examination of the change event/s, the woman's understanding of what is shifting may be limited. She needs to examine her perceptions and see how this motivates her actions to change over time. Consequently, transition can be viewed as a dynamic movement through disruption, to reshape a coherent self in the midst of shifting circumstances. The changes are often forced and the woman's current reality is altered, so she has to reclaim or reconstruct her new reality²⁰⁶. There may not be a discreet start or end point in the transition process, because changes and life events are faced by all humans on a regular basis²⁰⁷.

It is the changes that rupture a woman's sense of self which are the issues of concern to service providers. The self is not a fixed object, but a subjective reflection of the woman's shifting perspective of who she is at this moment and in these circumstances. Signs that transition is occurring include reconnection to, and interaction with, other people ²⁰⁸. The woman feels located again and has a sense of belonging and connecting with a group of people. Many women speak of feeling 'OK' or 'normal' and this is often indicative that changes have been incorporated and the woman's self identity is secure indicating she has transitioned successfully. She sees she has responsibility for her actions and can seize opportunities to exercise personal responsibility. As the woman masters new life skills her coping strategies improve and she develops a more flexible perspective about who she is. It is this adaptive capacity in a world of challenge that grows resilience and personal capacity ²⁰⁹.

As we have noted, transition is not a linear process and can involve a lot of backward and forward movement over time. However, for the sake of simplicity, so you can understand the concept and employ it within your work, we have divided transition into four phases. These phases are the familiar life; the change event/experience that causes the disruption; the limbo stage where the woman is neither in her familiar old life, nor has she incorporated the changes into a new way of life; and finally the phase of becoming ordinary, where changes are integrated and the woman has located a sense of self with which she is becoming content.

Familiar life

Life is recognisable and predictable, whether that is a backdrop of chaos, which was the case for many women in our study, or a stable family life. There is certainty in everyday experiences. The ordinary is captured in the daily routines and repetitions of daily living. The woman knows what to expect, even if that is not desirable, it is known. In this familiar life the woman knows her social roles of mother, sister, daughter etc. She is aware of her social status and the labels attached to her position such as homeless, addicted, abused, fostered, adopted, criminal, prostitute etc. Her sense of self is attached to those roles and the status they do, or do not, carry. This knowledge creates a sense of order, even if the order is chaotic!

...and there's anger, maybe that's it. I've always thought I can always smoke, or you know, I can go the big way and eat it all (but that would be expensive). But now that's not an option... it's not there for you anymore... that's scary. It's all ended and I'm not always sure I want it to...

This life may become so familiar that the woman does not see and experience what is happening around her. For example she may be in a violent relationship in which disorder and violence are what she expects. She survives the experience the best way she knows how. She may not be aware that what she is experiencing is illegal and socially unacceptable. This stems from a childhood where

abuse was all she has known as ordinary family life. There is continuity within her disruptive life. It is familiar and she is acquainted with its ebb and flow.

The change event that produces an ending

Life is full of endings. All people move through various developmental stages, employment, roles and relationships. Many endings are amalgamated without any sense of disruption. Some are anticipated with excitement and optimism. However, other endings cause trouble and disruption to one's sense of self. Entering into life is a change event that causes interruption to the normal patterns of living and being in the world. The old ways of responding no longer work and a new way to live has to be developed. The ending may be chosen (Eg entering a drug rehabilitation program) or it may be forced (Eg fleeing a violent relationship). The change may be desired and exciting, or obligatory and terrifying, and anything in between. The disruption ends the known way of living and forces the woman to change her connections, or anchor points in the world.

In western society our identity is strongly influenced by the socio-cultural interpretations around roles and status and connections within family and community. The ending may represent an upheaval and change important relational connections (Eg the woman must leave her children behind to gain entry into the rehabilitation program, or supported accommodation). This will affect her continuous sense of self as a mother and she will probably feel confused, uncertain, in conflict and fearful. Her reactive impulse may be to give up the change and go back to what is known and familiar. If a service provider meets with the woman at this time she will probably say she is 'confused', 'going crazy', 'can't cope', 'don't know what's going on', 'broken', 'cracking up' or similar descriptions. These feelings describe the personal and interpersonal disruption that the ending is causing. The woman is vulnerable and hesitant while she is in this state and at this time workers may need to take on a more protective and comforting role, ensuring her personal safety as the first priority.

The Limbo Phase

The woman will move into a state that is neither in the past, nor in the future. She is in an in-between state that magnifies her sense of difference and she often says she cannot cope. She may feel victimised, particularly if the changes were forced upon her. She may feel powerless about her capacity to live in such a changed environment. The landscape is new and foreign and she can experience disorientation by all the changes going on around her. She does not know the social norms and cultural nuances of this new context and it can provoke angst. She may be overwhelmed by the losses she has experienced and her grief may intensify once she starts to explore those wounds with you.

In the limbo state the woman dwells within and can feel very isolated and alone. She may think no one can understand her experiences and may not even have words to explain her feelings. It is a time of self-absorption because the task of that moment is how to reclaim self in the midst of change. The woman will most likely withdraw to do some self-examination. Self-absorption can become self-pity, which is an introspective perspective that turns emotions inward. Limbo is a time where the woman's sense of difference is heightened and she can feel very alone. It is helpful to have supportive companions for this part of the journey, and the group is certainly a place where women can find such support. What is familiar is gone and what is to come is not yet clearly visible, or achievable. The task in limbo is to commence the sense-making process. To work out the new anchor points which locate one's self within the changed landscape. For many women in this study, limbo was a time of mourning the losses, and grieving what might have been, had the CSA not shifted their life experiences. The worker's task is to facilitate sense-making activity by using the 'Look, Think, Act' process as one tool that assists this process within the therapeutic relationship.

...I get into these places I call limbo land, like a no-man's land. It's neither here nor there. My goals seem to get further and further over the horizon... I try to put it in my journal and then a week later it doesn't mean the same. It hasn't got the same impact and everything fades... and it's hard to get a grip on what is there...

The New Beginning that Leads to Becoming Ordinary

After the woman has made sense of her changing circumstances, she has to incorporate the changes created by the alteration in her role, status, personhood, or way of life. This requires her to reclaim aspects of her past identity that sustain a coherent self and reshape her personal identity with the new knowledge and information she has gained through the therapeutic relationship, or in the group work. As she incorporates changes and develops a stronger sense of self, she will increase her resilience and build her capacity to overcome adversity. These successes build confidence which in turn motivate her to take increased personal responsibility. Success develops perseverance, ignites hope and increases self-agency, which enables the woman to live independently with decreasing need for professional support.

As the newness of this way of life is incorporated, the woman faces significant choices that she must action. To achieve continuity she must choose involvement or discontinuity with significant people in her life. This can be a time when healing is painful. For example many women have to let go of dreams of a reconciled relationship with their childhood family because those people are unwilling to change their toxic behaviours. Maintaining such relationships is deleterious to the woman's health and wellbeing.

I don't think the reasons have disappeared, the reasons will always be there. But the way I have storied those within my head has changed. I think what I used to treat with contempt, rebellion and anger has changed into something else. I have become more patient and compassionate.

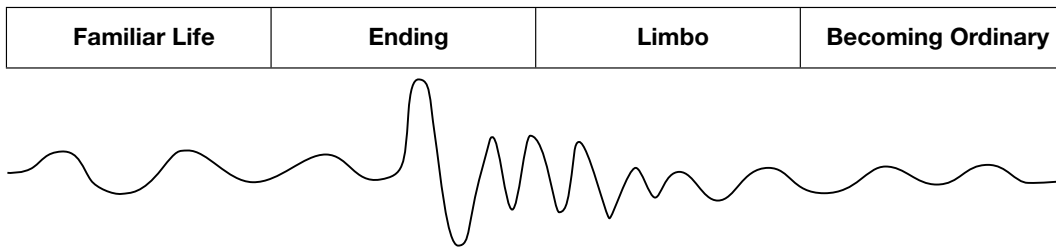
Being here (the group), and my kids actually wanting to be with me, has helped me work to be a better person for them. They come to me with their most intimate things now... and I don't want to lose that. To me that is more valuable than any amount of drugs or alcohol you know, or feeling bad for three days afterwards.

Re-establishing continuity promotes a sense of agency as the woman takes action and tests the reactions to her responses. There will be errors made but instead of interpreting them as verification of her worthlessness, the woman will begin to view them more rationally, as mistakes she can learn a lesson from. She will take some personal responsibility. It will help to re-establish daily life routines, as these promote continuity. This may be a challenge in supported accommodation where permanent connections and access to significant others, such as children, is limited. However, re-establishing relationships of value with significant family is of great importance. Similarly, the need for chosen disconnection with abusive and violent family is critical to ongoing wellbeing. It is extremely important that you work with the woman to co-create a close vision of possible ways of living and being, in her changing world. This will help her discover an orientation, meaning and purpose in her life, with which she can feel a sense of belonging and connectedness.

Over time she will discover familiar landscape markers that reveal to her a new landscape and her place within it. This facilitates continuity of her identity. Seeing herself in this new place often means the woman can see the changes in who she is now, compared to who she was before, and she can see the transition process in effect. The disruption may cause great suffering, but the shift in her attitude can mean she now sees her suffering as leading her to a deeper understanding of herself. The opportunities you provide for her to re-story her past and explore the social validity of her story will enable her to feel more 'normal'. The process of becoming ordinary, feeling OK, or 'normal' are indicators that the transition has taken place. Eventually the woman will come to a place where she feels integrated and more at peace with her situation and herself.

Figure 6.2

The Four Phases of Transition and the Experiences Engendered by Each Phase



This graphic represents the movement that occurs during each phase of the transition process.

Disruption changes familiar life patterns and forces the person into a limbo period where they must make sense of the changes so they can relocate new ways to live and be in the worlds and shift their sense of identity.

<p>Living and being in the world is predictable and situations are taken for granted.</p>	<p>The current way of living ends. The change event or experience may be chosen or forced, but life is different.</p>	<p>The changes, chosen or forced, may become disorientating. It can be a time of suffering and disempowerment. Moving through this phase is facilitated by sense-making activities.</p>	<p>Incorporating changing patterns of being and doing into fresh ways of living and being. Living life in a way that provides a sense of coherence.</p>
<p>In familiar life patterns you experience:</p> <ul style="list-style-type: none"> • predicability • identity • roles • status • location • situation • security • relationships • connections • internalised socio-cultural norms • thoughts, feelings, attitudes with self • ordinary life • acquaintances • internalised socio-cultural norms • thoughts, feelings, attitudes with self • ordinary life 	<p>Following an ending you may experience:</p> <ul style="list-style-type: none"> • disruption • difference • fractured identity • brokenness • over burdened • displacement • separation • disconnection • uncertainty • hesitation • insecurity • ambiguity • vulnerability • inadequacy • violation • victimisation 	<p>During limbo you may experience:</p> <ul style="list-style-type: none"> • confusion • turmoil • uncertainty • confrontation • alienation • isolation • loneliness • self absorption • self pity • incongruence • unanchored to life • betrayal • powerlessness • grief & loss • insecurity • disenfranchisement • extraordinariness • suffering 	<p>In becoming ordinary you may experience:</p> <ul style="list-style-type: none"> • new beginnings • transformation • growth • progress • continuity • return to ordinary life • feel 'normal' • realignment • reconstructing • revising • revaluing • reconnecting • reclaiming • refining • reconciling • returning to familiarity • relocation • renewal • mastery • healing • resilience • 'I'm OK!'

Facilitating Transition

I had an inkling then that the guilt and the shame thing was a wrong thing, but so many people use it as a power tool, you know? "Oh... We'll just shame her out of it" you know, "We'll just guilt her into it".

Transition can be facilitated by the 'Look, Think, Act' process. In the 'Looking' the woman will acknowledge things are different. This process is best commenced by just allowing the woman to tell her story in an uninterrupted manner. She will be helped by being asked questions that enable her to identify what has changed and what feelings, thoughts and emotions the changes

are triggering within her. You may find some of her thinking is distorted due to her low self-esteem. To correct such thinking, the woman may need to unpack what she perceives as 'normal' and get in touch with what is her reality. You may have to dispel some irrational beliefs and help her to see how these beliefs and thoughts are linked to her past CSA experiences. In telling her story you can assist her to identify the key issues with which she is struggling. You can help her to locate the strengths in her responses and the personal assets and attributes on which she can build her future. She will need to discard and replace former destructive life-scripts and perceptions of herself. We found that the women needed to practise self-affirmation and self-nurture. Once they develop healthier, realistic thought processes, their emotions shift. The woman begins to choose her actions and exhibit behaviours that are healthier, more rational and realistic, which results in an improved sense of self, enhanced coping and healthier life choices.

In order to heal from negative and self-destructive ways of living, the woman will need to get in touch with her emotions, thoughts, feelings and attitudes. Many women in our group had to be taught how to identify, name and express their feelings. We spent some time understanding that emotions and feelings have their place and purpose in life. No emotion is intrinsically bad or good, negative or positive. However, dwelling too long with some feelings and emotions can contribute to illness and suffering. Avoiding these feelings is not helpful because the feelings do not go away, they are just covered over and magnify with time. You can encourage the woman to get in touch with how she is feeling about the reality of her life. The group serves as a safe place for the woman to practise expressing her feelings, and listening to others voice their feelings. The woman will need to be encouraged to act only upon reasoned thinking. She will have to accept personal responsibility for her actions and responses.

The woman may need help to identify self-enhancing behaviours and plan strategies to effect them. It's important to note that a woman is unlikely to change her actions or behaviours before getting in touch with her emotions. She then needs to shift her thoughts and accept her feelings. Just changing actions, because it is the 'right' thing to do, is difficult to sustain. If her actions are not accompanied by the right motivation and feelings that support her chosen behaviours, the work

will be unsustainable and relapses are likely. She needs to alter her thinking so she experiences the motivation that sustains affirmative and authentic action, which will give her the outcomes that enable her to continue to see the worth in doing the hard work of healing.

Some key areas that require planned action include:

Grief and loss

Grief over issues such as sexual abuse in childhood, virginity, parenting possibilities and sexual relationships etc.

Former self-destructive patterns of behaviour

Patterns such as running away from problems, attitudes towards pain, violence, disassociation, addiction responses, etc.

Emotions

The 'Big Five' emotions of fear, anger, guilt, shame and love must be acknowledged, and named. Thought-through responses that affirm a new sense of self should then be enacted.

Power and control

The woman will need to spend some time exploring power dimensions in relationships and life circumstances. She will need to accept what is beyond her control and let that issue go, or accept it. She should be encouraged to action self-control over her mind and its emotions, attitudes, thoughts and feelings, and choose behaviours that empower her.

Interpersonal communication

The woman will need to learn how to focus on her own feelings, and those of the other person when she is communicating. Belonging to a well facilitated group role models how to listen reflectively and communicate with transparency and integrity, to solve problems.

Family and intimate relationships

The woman will want to take steps to grow and nurture personal behaviours that improve social relationships.

You will need patience and compassion because this client group often have multiple, complex problems and firmly entrenched behavioural responses. The woman will need encouragement because the work is hard and requires extraordinary persistence and patience, because progress can be slow. We found that holding a sense of hope that the future can grow, and having faith in the

woman's capacity to action her future, was an important motivator in the therapeutic relationship. As the woman starts to see her hard work pay off with a developing self-esteem, her motivation and confidence increase. There are setbacks and relapses, and as a worker you will need to help her see that this is the convoluted process of transition. It is not just a one way, forward movement, there is a process of progress and regress, but with time and perseverance progress is assured. The stalling phase of the 'Look, Think Two Step', where a woman sits with ideas and possibilities going to and fro in her mind, can slow progress.

Action the Catalyst in Transition

I got a thought in my head and that was, 'Do everything the opposite to what you used to do'. It felt good doing that, because when I did not want to talk to anyone I really forced myself to talk to someone and it was good. When I felt like I needed a drink of beer I went and got myself a drink of coke... I was doing the opposite. Sometimes it was just walking away from the tempting things and being able to do that felt so good...

The significant movement in transition comes with the 'Act' phase of the 'Look, Think, Act' process. It is the action phase that moves the woman forward most rapidly. If a woman does nothing but look and think, she will make slow progress, if she makes any progress. She needs to action her choices to make movement. Movement is directly correlated to her thought-through and planned action. Additionally, if the woman acts without looking and thinking, just because she is asked to, or it seems like the right thing to do, she will not be able to sustain her efforts. Action has risks and it can be easy to choose the safe option and do nothing. We found taking action was the hardest hurdle for the woman to overcome. She needs confidence to take action and face the consequences of that action. This is particularly so if the action does not have the outcomes she had hoped for.

The purpose of action is to put together practical solutions that facilitate the reshaping of the woman's future and the reclamation and renewal of her identity. Creating action plans is difficult but actually enacting those plans is by far and away the most arduous aspect of this process. It becomes that much harder when many of the woman's previous plans have ended in outcomes that were unwanted. The role of the service provider is one of encouragement. It will help if you can assist the woman to focus her thoughts on some opportunities that the change situation brings. In discussions of past ways of coping within the group we noted strengths in the women's past story. These were assets that each woman brought to her situation and they became the basis on which each woman constructed her shifting identity. The opportunities for success were increased if the woman had a support team around her that could reinforce her newly chosen patterns of living. In the absence of such support, and this is certainly the reality for many women in supported accommodation, the worker and/or the group were the woman's sole source of encouragement.

Creating the action plan

The woman needs to make some specific goals toward her desired outcome once she begins to see where she wants to go. It will help to ask her, 'What is important right now?' 'What is achievable for her at this time?' The woman may need assistance to clarify her priorities and support with defining the tasks that she needs to action, so she moves toward her desired outcomes. We found this to be a major struggle for most women because they are uncertain about how to create steps toward their goals and they are afraid of being too hopeful, because having their hopes dashed is demoralising. They lack confidence in their ability to make sound choices so they need assistance to define and describe their needs, and locate and link up their assets to see the strengths they have to meet their own needs.

When the woman decides on a course of action and she commences engaging the steps that activate her plan, she also finds she has responsibility and this is another difficulty for some women. They are anxious about carrying too much responsibility. This is an important point for service providers to note. The woman needs a lot of encouragement. She should commence actioning the smallest steps that are most likely to move her closest to her goals without too much effort.

The woman finds a renewed sense of purpose if she believes she can achieve her goals, so it is important to make the goals realistic, achievable, hopeful, and on the near horizon. We found some women become very productive, investing considerable time and energy into this work, reading books on the topic first, wanting to get knowledge so they can make informed choices. As the woman starts to see her plans come to fruition her motivation grows and her confidence develops. As a worker it is a huge reward to see a woman discover her own strengths and capacity. Most in our study were unaware of what strength they had. Seeing their progress and the joy they experience in self discovery motivates the worker to keep walking alongside women that many others may have given up on.

.....I'm beginning to notice there's a form in growth. There are certain things that come up like my isolation thing is changing. It's weird. It's as if when you grow inside, it's like when you grow in height, it is going to show itself! I know this, everything's changing. I feel like I know what I want. I need more out of life now than what I've had. I knew I needed to talk to you. I'm going to talk through these issues coming up in my life that are pushing me forward, whether I like it or not. You move, even if you don't like it, because you have to make a choice to respond. I mean, I notice it all now.

The Steps in the Action Phase

Plan: The first step is to use the decisions made in the thinking phase to devise a plan that deals with the issues in the order of importance that each woman assigns to her problems/needs. Develop

goals that clearly state the actions the woman wishes to take and order their priority. List some of the actions to be undertaken to enact each goal and then sequence the tasks that are required to fulfil each action step ¹⁹⁷. It will help to work out what people and resources, what time and the place where these actions should be undertaken, to get the maximum benefit from the action and achieve the outcome. The grid in Figure 6.3 can be used as a guide to creating an action plan. You may need several steps to attain one goal. It is best in the early stages to keep goals simple, achievable and focused on the near future. The woman can follow her progress on such an action plan.

Implement: The second step is for the woman to implement the action plan. She should commence this step by communicating with any people she needs to help her achieve her action plan. As her worker your key role is to ask her questions that will help her consider many options, encourage her efforts, and assist her to reflect on any issues that are obstructing her progress. She may need to do some more looking and thinking through issues so she can clarify what is going on. If things get too difficult in the early stages you may have to assist her when the going gets tough. You may be able to direct her to other resources and people who can help her to achieve her goal, or help her set more achievable and realistic goals.

Evaluate: The third step is to review the efficacy of the plan and monitor the progress toward the stated goals. It will help if you ask the woman questions that assess the effect of actions and activities. You may need to highlight her achievements as she may focus on what is not working. Celebrate all progress toward goals and highlight the important lessons learnt when some aspects of the plan are not going as hoped. Ask the woman to prioritise the remaining issues and make any revisions to the plan so she is moving toward the overall goal she desires. If large obstructions come up, the woman may feel like giving up. You can assist her to find ways to modify her plan into more manageable steps. This can be done in writing, or it can be done in a group or one to one counselling setting. She may recognise that things have to change, but if outcomes are not seen she will become discouraged and may give up. One woman in our group reminded us of the consequence of going back to old patterns of coping, saying *'If we keep doing what we always did, running away, numbing the pain, ignoring our hopes, dulling our mind then we will keep getting what we always got from that lifestyle... nothing but pain and suffering'*.

The questions to ask that promote the woman to action are discussed in Chapter 1 but they are summarised again in Figure 6.4.

Figure 6.3

Creating an Action Plan

Goal - near, focused, and achievable	Steps toward achieving my planned goal	People who can help	What do I need? (money, equipment, time, services)	Planned time and place for action	Progress/Outcome
1.	1 2 3	• • •	• • •	Place: Time:	
2.	1 2 3	• • •	• • •	Place: Time:	
3.	1 2 3	• • •	• • •	Place: Time:	
4.	1 2 3	• • •	• • •	Place: Time:	

Figure 6.4

The Look, Think, Act Process Can Facilitate Transition

<p>Look</p> <ul style="list-style-type: none"> • What's going on? • What's happening? 	<p>Think</p> <ul style="list-style-type: none"> • How am I feeling about it? 	<p>Act</p> <ul style="list-style-type: none"> • What do I want/need to do right now? • Who can help? Where? When? How? <p>THEN DO IT!</p>
<p>You build a picture based on information available to you about the issues you are dealing with. From here you locate the areas you want/need to work on to move forward.</p> <p>Describe:</p> <ul style="list-style-type: none"> • What is going on? • What are the circumstances? • What thoughts are in your head? • What emotions are being triggered? • What are your responses? <p>Gather information, build a picture:</p> <ul style="list-style-type: none"> • Who is involved? • Where is this change occurring? • When is it happening? <p>Describe the context:</p> <ul style="list-style-type: none"> • Try to get other people's views on the situation. • How much are you mulling over the event/experience afterward? 	<p>Try to get a better understanding and meaning of the issue, so that you can work out what you need/want to do about it.</p> <ul style="list-style-type: none"> • What is the main problem? • Why is this happening? • What do you think is the trigger or cause? (Eg attitudes, beliefs, past experiences) • What are the consequences? • How are you behaving? (Eg are your responses appropriate? Are they reactions that are grounded in the past?) • In which area/s can you move forward? • How might this moving forward look? • When and How should you begin? • Who can help you? • Is such a plan possible, given the changes that have occurred? • What might the anticipated consequences and outcomes be? • What are your strengths? <p>Focus on what is possible in the situation.</p>	<p>Adversity provides little choice about the need to change; you can only choose how you will change. Thinking about change does not affect change. Doing nothing is a choice!</p> <p>Set your personal action goals and then plan how you will make them happen. Become involved with your situation and choose the actions that will take you toward your chosen goals.</p> <ul style="list-style-type: none"> • Focus on the opportunities change can bring. • Draw on your past strengths. • Have support people who can reinforce your new patterns of living. • Take specific steps toward your desired outcome. • Do what is most important now. • Start with the smallest thing that is likely to have the most positive impact on your wellbeing with the least work. <p>NOW TAKE ACTION!</p>

Summary

This chapter explored the four phases of transition that were uncovered in this research and the way the 'Look, Think, Act' process can be used to facilitate movement through these phases focussing on 'action', the final part of that process. It helps if a worker is able to assist the woman to pay attention to the meaning she brings to her experiences. In so doing, the woman becomes more mindful of her attitudes and reactions and can more easily consider ways she might shift her thoughts and attitudes about her situation. The worker can help her unpack her assumptions, some of which will be personally constructed and others will be socially reinforced beliefs. Many of these beliefs will have escalated the woman's suffering and stand in the way of her ability to take personal action and develop responsibility for her behaviour. It is imperative that the 'Looking' and 'Thinking' phases of this process challenge the mind pictures and the meanings the woman holds about herself and her situation.

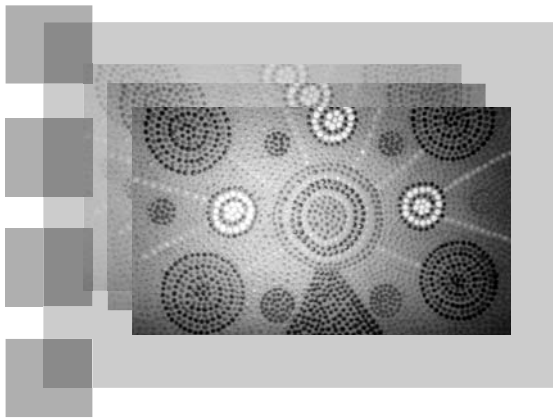
These phases of transition start with life as familiar in an understood world. Then a change event/experience may cause disruption and a limbo phase develops. In that phase the woman is no longer living the predictable life she knew, nor has she incorporated the changes that have occurred into new ways of living. Finally, the changes are integrated and the woman locates a sense of self with which she is content. This is the phase we term, becoming ordinary. We found that the best way to facilitate movement through each phase occurs when you allow the woman to understand the meanings she has ascribed to the behavioural and emotional patterns she developed during her childhood. This helps her to understand how those meanings influence her thoughts, feelings, emotions and actions throughout adult life. We encourage the woman to hang on to beliefs and actions that return her to compassion for herself and others, and nurture connections between herself and those she loves (non-abusing family and friends), the natural environment (pets, plants, landscapes) and the spiritual (God/Higher Power). If the woman actions changes that strengthen those areas, she finds hope, meaning and relatedness which secures important aspects of her identity in a new location in her world.

Transition is effected when the woman faces the disruption caused by adversity and sees how her responses exacerbate or ameliorate her vulnerability. The worker can help the woman to face the challenge of reclaiming aspects of her identity and reshaping her sense of self, so she feels OK about who she is now. In so doing, she will master coping skills and recognise strengths and personality attributes that demonstrate her resilience and capacity. The real excitement comes when the woman sees she has personal control of her life. This control resides in her attitudes, thoughts, emotions, and the ability to exercise her freewill to action her choices. This knowledge helps the woman to control some of the more impulsive reactions that characterised her past responses and she experiences the empowerment of taking more personal responsibility.



Chapter 7

Suggestions for Good Practice for Service Providers



In the previous chapters we looked at the literature around CSA to provide a background to the research. We discussed the benefits of the method we used in this study to build capacity amongst the participants. This chapter provides a summary of the practices the participating women and service providers found useful in working with women survivors of CSA. There are many documents and reports that discuss similar findings so we chose not to repeat information that was freely available, focussing instead on process issues, within this resource. However, it would be remiss not to report what service provider participants have noted that works well in their practice. We also briefly present what the women participants said they want/need, or appreciated, when they use services. These points have been grouped over two years and are supplied in an abbreviated manner as suggestions to guide good practice.

Good Practice re Facilitating Disclosure of Child Sexual Abuse

The women wanted to share the practices that enabled them to speak out about their CSA. These points are presented so service providers can consider how they may prepare and support their workers to achieve more of these behaviours and facilitative processes.

The women noted that they minimised, discounted and ignored that fact they had been sexually abused during childhood, for most of their lives. The reasons for this varied, but they included shame and embarrassment; fear of retaliation from the perpetrator and concern that they would not be believed. This led to many women discounting their experiences, denying they happened, instead choosing to block them out. Once a woman acknowledges the past CSA she can begin the process that allows her to separate herself from her experiences.

Before the woman can voice her story she needs to be ready. Being ready and prepared to work at remembering and healing is a process that requires energy, safety, and stability in the woman's family and personal situation. Many women are unaware of how to get help and may look for it in different ways. For example some women said they presented to the doctor frequently with minor ailments, or they harmed themselves. Looking back the women said they wanted to get help, but did not know how to ask for it, or where to go. This was made worse by the emotional confusion they felt inside themselves. Most said they were not asked about CSA by service providers. On the occasions that they were asked, they would usually divert the conversation to something else, because they found it impossible to talk about CSA and then walk away from the conversation feeling alright about themselves. An astute professional will help the woman find the courage to voice her experiences.

The women noted that the key factor that facilitates disclosure is a professional who listens attentively to the woman's story and believes her. This professional knows what they are listening for, and accepts the woman's story without suspicion and judgement. They hear exactly what she is saying and give her the time she needs to find her own words to tell her story and share her concerns.

The women say they feel safe enough to disclose CSA to a worker when:

The therapist is approachable and understanding

Survivors are insightful about professional acceptance and engagement. The woman needs to be believed, so she will only tell someone if she is confident she will be accepted and understood. The woman can tell if a worker is 'disinterested', 'nosy', 'voyeuristic', 'judgemental', or 'labelling from their text book references instead of listening to my life references'. Allowing the woman to tell her story, while listening authentically and actively, is critical to good practice regarding the facilitation of the survivor's disclosure.

The willingness of the therapist to explore the CSA

Several women had stories of professional encounters where a worker did not want to speak about CSA, and stymied the woman's attempt to disclose. For this reason several women said they 'tested the water' with specific statements to see how workers responded, before they carried on with their disclosure. Therefore it is useful for workers to ask a woman directly, on several occasions, using different descriptive words, throughout the interview. This will give the woman plenty of indication that you are ready and willing to listen.

I was fearful of further rejection and I wasn't going there if there was even the slightest chance of being fobbed off.

An open, honest and transparent professional agenda

The women note that their life experience had shown them that people often have ulterior motives and hidden agendas when they deal with them. This has made them insightful, perhaps suspicious, and sceptical of people who want to know the details of their story. They worry about not being believed, or being blamed, or judged. Sometimes people do this inadvertently by asking questions that are preceded by 'Why didn't you...' 'Why' questions almost always appear judgemental and should be avoided wherever possible, because the woman leaves the interaction feeling blamed. It seems important to reassure the woman that she is in control of the conversation and she only needs to share what she wishes to speak about.

An interested and engaged professional

The women often said they felt as if they were being assessed, rather than heard.

I felt as if I was being rated so I could be given a diagnostic label and my free ticket to Glenside. I didn't feel as if she really wanted to help me, it was more her deciding what she had to do with me.

Another woman noted that the worker's motivation and engagement had more of a personal agenda than a professional purpose.

It seemed as if she was more interested in getting me to receive God than she was interested in helping me sort out my problems.

A supportive environment and close appointments

The woman needs to know she will be free of the fear of repercussions from therapists, family, friends, employees and the society in which she lives. Knowing she is going to be safe and supported for long enough to face her pain, allows her to speak. The women expressed that a well of despair, anger and desperation was stirred up by talking about CSA. Therefore the woman who is to disclose needs to know she has several closely scheduled appointments immediately after she first discloses, otherwise she will most likely not speak about it.

I have been seeing the same psychiatrist for the last fourteen years off and on. When I first started seeing her she said, "We really have to get to the crux of this child sexual abuse". To this day I still have not spoken to her about it. Whenever she thought I was getting to a level where I could cope with it, she would bring it up, but I knew I would not see her for another six months, and I would be desperate in between. It's just not possible to talk about it in this way, as I can't stand all the feelings that talking about it brings up within me. I can't manage all that pain and live in the present moment.

Some suggestions about how to ask questions about CSA

The point of disclosure can determine which direction a woman's life goes, depending on the response and support she gets from the worker. Service providers say they had success facilitating disclosure by asking:

- What has brought you to see me today? Then work back from there.
- Some of our clients have experienced sexual abuse when they were children – could this have happened to you?
- What has been happening lately? Be interested in her life and help her explore it.

Consider the language you use in your conversation, because your terminology may not be the same as the woman's, so unpacking language to ascertain meaning is important. It will help to normalise discussion about CSA, so you ask the question the same way you would ask her questions about her housing history, family history etc. It helps to be up front with the woman, saying 'This is about you, so let's go through this and you tell me if I've got anything wrong'. In this way you can check that you are both speaking the same language and making congruent meaning. The woman feels empowered and knows she can correct anything that is misunderstood. It allows her to start with a clean and accurate slate with you as her worker.

Service providers can assist workers to be more available and understanding so women feel more able to disclose CSA. Some good practices that have been noted include:

- Disclosing should always be at the woman's own time and speed, as part of the healing process. Once she has broken the silence, she usually feels huge relief, but it can be distressing.
- Provision of in-service education regarding CSA and its relevance for quality service. The response of whoever the woman tells the first time, has a lasting impact.
- Help workers to reflect on their practice and look at their behaviour and examine personal views. Cultivate empathy and compassion, because these attitudes have a huge affirmative impact.
- Discuss ways you can find the right language and methods of asking about CSA that suit the clients within your target population.

- Realise flexible approaches are required because what works for one person might not work with another, and one service setting is different from another.
- Discuss readiness and how you can facilitate this in your service. How do you know someone is ready? It is best to ask the client if they are comfortable in discussing this issue.
- Help workers to overcome their fear of the unknown by explaining what is going to happen. The client may not know if they are ready until they are asked.
- Women may have an expectation they have to give detailed accounts of their story if they are asked. This fear needs to be allayed and the woman needs to be reassured that she will control the conversation. She only needs to say what she feels comfortable to say. There is never any need to give explicit detail.
- The woman needs to know you are prepared to hear her story, but she is not expected to talk unless she wants to (ensure you don't underplay the value of disclosure). Some women do find it healing to know that they can tell you the horrible parts of their story in confidence, knowing you will be strong enough to hear the facts. Therefore you must be prepared to listen to the woman once you invite her to speak.
- Receive the woman's story in a calm manner – do not dramatise it. Try not to treat it as if it is an 'unspeakable' story. You should be calm and display concern, but try to remain somewhat matter of fact, or the client may be concerned she is hurting you.
- You may need support as these stories do have an impact on you. These women are ultra-sensitive and easily feel responsible for how others are feeling. The client needs to know you have support, so she does not feel responsible if you become upset. If you do cry (and most of us have), just reassure the woman you are alright and she does not need to worry about this. Reassure her that your tears are empathy for her. With such explanations, tears are likely to be therapeutic and not harmful to the relationship, or the woman.

Good Practice re Therapeutic Help

This was discussed in depth in Chapter 2 but suffice to say that women are more likely to speak to a worker who displays acceptance, trustworthiness, empathy, real caring and demonstrates that they believe the woman. If the worker can help the woman feel relaxed, supported and cared for, she will be more likely to disclose.

Helpful qualities in the worker

As the woman's worker it helps if you can:

- be authentic and willing to take some calculated risks with the woman;
- respond with genuine concern and not shock horror, disgust or disbelief;
- be an empathic person;
- use your skill to communicate clearly, especially if the woman is confused and vulnerable (service providers should monitor staff and provide education and training);
- gently challenge the woman's old ideas, beliefs and patterns and present new ways of thinking and alternative perspectives to consider;
- help the woman name what is happening to her and put herself in the picture in a way that she has not done before;
- encourage her, by providing several options, to tell her story and speak out, such as drama, diary, story groups, psychodrama, ethno drama etc.
- help the woman identify her strengths and stories of resistance;
- help the woman define patterns of resistance in her story so she can use these to support the way she is to be/become over time;
- work at the woman's pace;
- check that you are providing opportunities for her to talk about what she wants to talk about;
- be a witness to the awful things that have happened to her, but help the woman to realise she is more than the abuse story and that her whole story is not all pain; and
- reflect on your practice to ensure you are not replicating abuse of power in your conversations with the woman.

The worker keeps the woman in the feedback loop

Most of the women have had to deal with multiple aspects of the health system, so they have told their story over and over again. They can relive the pain every time they tell it. The women are asking for better communication and networking between service providers so they don't have to repeat their story to too many workers.

I think there needs to be more communication, networking and linking up. Each one (service provider) only thinks about their own area. You are telling your story to so many people and that makes yourself vulnerable. It hurts every time you do that.

The worker promotes the woman's self-agency

Some women want more self-agency regarding their own case management. They are aware they have multiple problems but they belong to the woman. They want to be kept informed and consulted regarding their case management so they can have input with their worker about what they need/want. There will be times when the woman prefers to let the worker make the decision for her, perhaps while she is in crisis, but she still wants that choice. The woman needs support to reclaim her life and make appropriate decisions re self-care and this is facilitated by services that promote personal agency.

I went to Centrelink to get help for my kids and they took them away but they wouldn't support me. I was so angry. I want them to know that this is a real issue for me. They should be linking back to me here at X, or wherever. They should be communicating with me about MY children. Give women the ability to say what they want to happen. We are in a bad situation and it is unjust to continue to ignore us. I had to walk out of a violent marriage. I had to leave a violent family home. I have lived a whole lifetime of being ignored and disrespected. I have only just started to see that I can be assertive about my rights and I am nearly fifty. I have wasted a whole lifetime and I feel the system has contributed to my suffering.

The worker ensures further opportunities for ongoing disclosure

Women say it helps to have follow up opportunities to deal with impacts of CSA. Women may disclose their experience of CSA but minimise the impact that it has on their lives. The women have said they thought they had 'dealt with that years ago' and workers then dismiss it and get caught up in other important issues. Time constraints mean the opportunity to discuss the impacts of CSA with the woman are not repeated further into the relationship. The women say that it helps to be asked how they are coping with past CSA experiences. They want information about who they can talk to, what impacts CSA might be having on their adult lives, and repeat opportunities to re-enter the topic if they need to do more work on it.

The service is perceived to have a trusting culture by the woman

Some services are highly regarded by the women because they promote safety, respect and dignity for the women they work with. This provides an environment that encourages trust, so the women feel safe to return. This reputation is not based on the standing of individual workers, rather it is grounded in the organisation as a whole, because all staff working within the service hold similar values and principles to guide their practice. The women know what to expect and can begin to embrace such values as helpful ways to manage their own lives.

The service can assist the woman to obtain her most basic needs

Strong bonded relationships are established with vulnerable women because services meet the woman's needs and assist her with practical tasks such as maintaining accommodation and establishing independent living skills. The worker role models problem solving and decision making when she is advocating for the client. The women note how they learn by observing such workers. The process of getting to know each other is enhanced via the completion of less threatening tasks where the woman has the opportunity to feel safe enough to discuss other aspects of her experience with a worker. This relationship building gives the woman the opportunity to speak with someone who acknowledges and validates her feelings and experiences, without feeling like that person has an 'agenda'. The women in this project said they felt this was a very helpful strategy.

For women recently released from prison, or women escaping domestic violence, the relationships that they build with allocated workers may be the first time in a long time (if not the first time in their life) that the woman has been able to establish a safe and trusting relationship with someone who does not want something from her. This breaks down the barriers and begins to open the space for disclosure so she can work on deeper issues such as CSA.

Good Practice re Creating a Safe and Friendly Environment

The need for respect and confidentiality

Many women have been in situations where they were admitted to a hospital in a distressed mental state. The hospitals were usually large metropolitan teaching hospitals which had students doing clinical experience. Consequently extra people asked to sit in on their interviews as part of their learning experience. The women are in a vulnerable and distressed state and said they felt powerless to decline this request, noting the experiences of additional people added to their suffering. Too many women had stories of broken confidentiality, lack of privacy and insensitive treatment which bordered on disrespect. The women's words tell the story;

...every time I would go to see the psychiatrist they would ask me if I minded the students coming in. I didn't feel as if I could say no. I felt as if I was a guinea pig all the time. They sat there writing all the time, they were not interested in me, just the gory details of my story.

Six people sat in on my interview, watching me reduced to tears and then thrown out of the door with an out-patients appointment. They would give me a tablet and if they could see a smile on my face then they think 'She is fine' and I was ready to go.

They treat you like you are 'one of them' - those trouble making single mothers who can't cope... if they knew half of what I had been through they might act differently, but they never bother to ask. They just take your blood pressure, fill their charts, hand out their medications, ask you if you are alright (like you'd be there if you were!) Then as soon as you look OK, off you go back to your fox hole for another round. Their job is done and they just want to get you out of their air space. They really don't care.

The experiences I had was one of humiliation and embarrassment. I felt like a freak show exhibit. Everyone came to have a nosy, because it was a reality TV show to them. I could hear staff speaking about me in the next room. It was embarrassing. In all that, just one nurse said to me, 'You have been through hell. You are a brave woman and you deserve much better than this'. It was that line that kept me from tearing the drip out and signing myself out. At least one person could see me, and not just "a juicy domestic".

The service providers noted that hospital practices made confidentiality and privacy issues difficult to implement. For example, case notes were available to many people to read. Some workers got around this problem by asking the woman what she wanted recorded in her case notes. The worker asked the woman 'What would be helpful for medical staff to know? What do you want them to know about your family?' Some workers asked the woman if she wanted to help write what was in her medical record. She was then invited to co-sign the document with the worker. Women find this both empowering and honouring.

A woman friendly environment

The women note that certain environmental aspects make some places friendly to women. They said first impressions do count. It is important to have friendly reception areas that are staffed by nurturing people. The women said:

- they would not disclose if they knew they were not going to stay with that service provider for a reasonable length of time;
- it helped to know the criteria for accessing particular services and information on how the service worked;
- knowing what rights they had regarding written documentation and issues to be discussed at the first/intake interview;
- they need reassurance of confidentiality of their story and clear knowledge of what happens to their records;
- they know when an organisation is serious about their values because they are embraced across the whole service and adhered to;

- some services have so many rules that the women feel imprisoned by the protocols;
- they are often more comfortable in an environment where there is only one gender present;
- they have to be in a safe space within their life (Eg Once they were in long-term safe housing the woman was more likely to speak about these issues). The woman cannot be in prison, or on the street, as she cannot lose what coping ability she has by disclosing, because this would place her at great risk so she may be vulnerable to further abuse;
- it helps to have some things/people that make the woman feel secure and safe Eg One woman says she needs to sit between the worker and the door. She needs to have doors open and space around her if she wants to be able to stay in the room; and
- they appreciate some space to go away and reflect or regroup before coming back to the group. Several women note how helpful it is to have the ability to come back after having a coffee, a drink, or a cigarette, where they have some time to think about what else they want to say.

A good number of the women speak negatively of addiction rehabilitation services. This is not because of the service provided, but the lack of safety the women experience in these places. Some say dealers target these places. Others say they are male dominant environments that are unsafe for women. One woman said her safest experiences were in the prison environment. She said for her it was easier than life on the outside. This may be an indicator of the level of institutionalisation she has experienced, but it may also be a sign of the vulnerability she experiences when she is in the community.

The women say it is helpful when a person gets seen for the first time, if a key worker is appointed based on the woman's most urgent need. In many cases the women said a generic caseworker was ideal, but such positions are no longer funded as the service models have moved towards specialised services. This model presumes the woman can be her own caseworker, accessing different services and facilitating contact between different workers. It presumes she can manage information about herself, which may be true for some women, but not others. One way self management can be promoted is by keeping a clinical diary with information the woman chooses to have in it. Services can enter data that is useful for other services to know. Problems can occur if the woman loses or forgets her diary. Most service providers agreed that there should be alternative and innovative models trialled that promote better self management.

The suggested models embraced by the women were those focused on case management using 1-2 key workers with whom the woman could identify (successful models from the mental health arena were provided as examples). Such models require workers to have expertise in more than one key area and organisations to support one another in the coordinated care of clients. It requires the

capacity for rapid referral across the sector. Such workers need to have broad skills in generalist case management and liaison with other services. This may be difficult to achieve in the prevailing climate of community services where specialisation is increasing, and less generic services are available. The largest hurdle to such approaches is the current funding policies and procedures which have shifted away from generic approaches. Collaborative work practices and agreement between service providers that the woman should choose the best way to manage her issues could be a starting point for modified case management approaches.

There are always conditions that need to be created for outcomes to occur. Some conditions that could be implemented include improved collaborative work practices between services; encouraging workplace systems that allow a woman to work intensively with a key case worker, rather than multiple workers who have large numbers of clients, necessitating minimal individual client contact; and Government structures that recognise that having large quantities of clients does not necessarily provide quality service delivery, or effective outcomes.

Women also appreciate services run on a state-wide outreach model, rather than a regional location based model. Currently a woman who moves from region to region has new workers assigned to her case each time she shifts out of the geographic region. The women are requesting a primary case manager if this is feasible. Two examples of this model come from statutory workers used in correctional services and outreach workers used by Offenders Aid Rehabilitation Services. Service providers feel the prohibiting factors are the cost but they say this is not an impossible hurdle to overcome when considering effective support models.

Everything's got conditions. You've got to be alcohol-free, drug-free, but sometimes I get this enlightenment thing when I am drinking. You know you are still there and you get that revelation to change and there should be somewhere to go while it's in your head. But you can't, because you aren't allowed to be there if you're using. There's no safe protected place to just think, or talk it through. I still see some of the same women out there doing the same thing – just moving around from service to service. Where can they go, if in the middle of using, they get the sudden urge to get out of the mess they are in? Is there a place, where no matter what you're on, you can go there to start the thinking through process? Do you have to go through the traumatic situation before you can get support?

Good Practice re Service Provision

Flexibility in the support services

The women said there are times when they are so low that they cannot do anything. At such times keeping a scheduled appointment is difficult, if not impossible. While they recognise the difficulty of rescheduling appointments, they are requesting some flexibility and responsiveness in appointment systems.

Some women say they want a safe, women only, retreat place. They could go to it when they are at risk of relapsing and dropping out of recovery programmes. An example is the retreat house 'Mayumarri', located in the Hunter Valley of New South Wales, founded by Liz Mullinar and officially opened in 1999 to provide adult survivors of child abuse with retreat facilities and live in courses, to deal with their past abuse. Such a retreat home could enable a woman to think through issues and sort out which direction she wants her life to go.

If we 'stuff up' we are immediately 'blacklisted'. It takes time to change. You cannot just snap out of a life time of behaviours overnight. We may come around several times, but each time we have a little bit less baggage and we are more prepared to start working.

Some women wanted a safe place to use. Needless to say, difficulties arise regarding use of drugs/alcohol, if a retreat facility is to be safe for all occupants. The women express the need for tolerance within the system so there is opportunity to accommodate the reality that many persons in recovery do have minor relapses.

Other women said they just need short breaks from the intense work of rehab. This time is to sort out what they are thinking. They want a space that is substance free, with rules in place, but a space that provides some time out from the rehab program to think. They have decisions to make about whether to continue with rehab, go back home, or return to the streets. They need a neutral space to sort through their options, but the place must be safe.

Other examples of services that would be appreciated by women needing residential support are more short term places, because when you are relapsing, or tending toward suicide, but you are not yet homeless, there is nowhere to go. The woman will become homeless without timely support, but support cannot commence until she is actually homeless. The women request additional services that are prevention focused, rather than crisis focused. They recognise that Government funding is a barrier. Service providers note additional prohibiting factors are the difficulty in providing measurable outcomes in preventative support programs. In a funding environment that is biased toward outcomes and evidence bases, subsidising retreat programs is unlikely to gain a high priority without evidence that it provides tangible benefits.

I did talk to a few people and kinda tried to say 'Help', but not 'over say', if you know what I mean. I was feeling really bad and my body's saying 'use' and my head's saying 'No'. Then it got to a point where I couldn't talk. I probably would not have used, if I had been able to talk. I had come to the point where I was talking to people and I wasn't using, but I still felt there was no caring interaction coming back, which I think now was probably an excuse you know... So alcohol, drugs, it's just to ease the situation, you know. I wasn't comfortable in what I was doing, so to 'dis-ease' that pain, I'd use. Then I'd think, well that's not enough to get rid of it, so I use more. In my sub-conscious I was saying, 'No-one cares, no-one really understands', you know. 'No-one's really trying to reach out to me or anything, so maybe I'm not meant to be here any more'. That's how you rationalise what you want to do and when that starts happening, that's when you bust.

Places for women and children

The women express a great need for places that allow them to be with their children, or maintain safe access to their children. They say not knowing what to do with their children while they are in unsafe family situations can be really traumatic. Leaving the children behind so the woman can access help and safe housing is an excruciating experience according to all participants. They note that they want to move out of violent relationships but not having your children increases the sense of hopelessness the woman feels and readily triggers her addiction patterns. Leaving children behind multiplies the distress in leaving, but they have little choice, because they cannot access the support services they need until they have left their children behind.

When you have got your children, it is very hard. I thought I would battle it on my own. I couldn't. So many doors closed in my face because I had children, so I had no choice but to leave them. I did make sure my kids were safely taken care of first, but I hated that. I hated myself. I felt bad enough, but to abandon them was almost the last straw for me.

We are going through enough, without the trauma of leaving our kids and they don't take that into account... that is the most traumatic thing, being on the streets and trying to get a glimpse of your children... That is terrible. I will never forget that.

An educated workforce within the service

It is considered important to establish an approach that educates workers regarding CSA, from the outset of their training, right through to refreshing their knowledge and skill base once they are working in their profession. All generalist workers who work in the social and health fields need this awareness. Women's Health Statewide is providing such services to health professionals, which is a model that can be adapted by other professions. This specialist training should begin while the students are completing formal studies in disciplines such as social work, youth work, community work, health, nursing, teaching, policing. This education needs to be placed in the same priority as

mandatory notification training. Service providers need specialist training in how to respond to initial disclosures of CSA; how to follow up; how to offer consistent support to a woman trying to deal with her experiences. Professional bodies are ethically bound to provide such education and training, and can incorporate education regarding CSA as a condition of maintaining professional registration.

Good Practice re Accessibility of Services

Support at many services is tied to particular funding provisions, such as accommodation. This means that when accommodation breaks down because a woman may not be ready/able to adhere to the guidelines of the service due to her addiction, the woman chooses to, or is required to leave the service. This puts a stop to some very good work that the woman has done regarding her CSA and other deep issues. Leaving the accommodation halts that work. As we noted trust and safety are key issues so the woman may not pick up this work with another service, until she is in crisis again.

It would be helpful if there was broader scope for continuing services, such as counsellors or support groups after the woman has left the accommodation. This is particularly so for clients who have begun to work on CSA, as there is a shortage of support groups for this population. Such groups could offer vital links to services that the women have already experienced to be nurturing and trustworthy.

Providing on going support

The worker should always have support to offer the woman after therapeutic conversations, because women can, and do, disguise their hurt. They say they've dealt with the issue, which is especially true for the women prison population, and the truth is they have much unresolved suffering.

I have developed skills, but also I found skills I had before. I lost them as they were buried under the mess I got myself into. Once my confidence went, my family went, my sex life went, my ability to think went, every thing went. Your self-esteem rules you. How can I negotiate with a Government agency if I have no self-esteem? I should never have been kicked out of my house in the first place. It's because I had no self-esteem when I was in such a low place, so then I didn't pay. I stopped paying rent for six months. I went through a stage where I just thought, 'Stuff the world' and I didn't pay my bills. I guess now I recognise what an idiotic thing to do, but it was my sort of protest. I know there are consequences now. I guess I just don't want to go back there again.

When working with women who are more disassociated

It is important that workers know about the problem of dissociation via in-service training. Many survivors struggle to stay present in their body and it will help if the worker can understand this and facilitate her engagement. Some points that help include:

- The woman may find it easier to have email or phone contact to get her thoughts out in a less confrontational manner (this is not possible for many women who have no access).
- When the woman is clear about what she can talk about, focus on what's important to her.
- Make the counselling session much less about the trauma and keep conversation lighter.
- In a group situation – talk about what it means to come to the group, so each person starts to feel connections.
- There are a number of excellent hints in the accompanying women's resource that will help you work with dissociated clients.

But the thing I can't really stop is that detached feeling. I have to be really detached to sort of try and push aside my pain so I can do things. If I start to think I wouldn't stop, I keep thinking until I hurt myself, so I just don't think about it. I just think about numb, you know. I'm either thinking about numb or what I'm doing, like watching TV, or doing the washing... I know it's not really good for me, but that's just what crops up really quickly. I can't stop it from happening.

Referral of younger women to CSA counselling services

It is not enough to hand a woman a brochure about CSA services and expect her to follow up with an appointment because most generally will not do it.

- It is good practice for student counsellors to refer students to appropriate services. If possible accompany the young woman or child, to the initial appointment. It is important that students get support to attend their first appointments.
- It is helpful if the school counsellor rings an organisation while meeting with the student. The young woman then has the opportunity to meet the service over the phone first. This makes it less scary to meet the counsellor face to face.
- It is difficult to keep young people coming in for counselling, once the crisis has passed. They want to get counselling over and done with quickly. Consequently, they do a lot of minimising because they want a quick fix. The preference is to suppress their pain. Many younger women do not see the effects that CSA is having on them. They do not think it may continue to have ongoing impact in the future, if they do not deal with it now. This was born out in our study in the different responses between the two groups of CSA survivors. The younger women tended

to think they could manage, while the older women could see that they had also had such thoughts when they were younger. The older women saw in the younger women, an earlier picture of themselves. They spoke candidly about how they wished they had continued to do the counselling work at a much earlier age.

- It is important to be aware that there are many time pressures on young women, with school, work, relationship strains, Year 12 studies, etc.

Good Practice re Community Awareness

The women want more health service providers to educate their families and others in the community regarding their understanding of the impacts of CSA. The women hope this will help people be more compassionate and understanding about the trials survivors face. Some suggestions that were put forward for promoting community awareness include:

- **Brochures** for the general public on what to do if someone tells you they have been sexually abused as a child.
- **Brochures for child workers** on what to say if a child says 'Dad wants me to touch his penis', or similar statements.
- **Brochures for teachers** and first-point-of-contact workers, on how to ask the questions around CSA and where to refer the person.
- **Raise awareness in the public arena** of how CSA is a key pathway to mental illness, addiction and homelessness. It is not a single tragic event, and it can have long lasting impacts.
- **Workshops for workers** and service providers on how to work with CSA survivors. Women's Health Statewide is a key service provider in this area and they have produced several informative fliers, reports, and public awareness campaigns available from their website.

The media interest has grown since claims of paedophilia arose within church organisations. In response the Labour Government in South Australia called for 'The Commission of Inquiry (Children in State Care)' to be undertaken by Justice Mullighan in South Australia. This commission has taken 780 statements between December 2004 and August 2005 and 650 of these claims relate to sexual abuse while in state care (www.statecareinquiry.sa.gov.au/). The ongoing media interest has exposed paedophile cases in schools, religious organisations and community groups working with children, across our society. It has caused many organisations to establish management protocols aimed at protecting children. However, discussions on this topic have raised concerns among some women. They note that their sexual abuse occurred within the family, and they wondered how children were to be protected within that unit. The women are also concerned that administrative reactions may

be motivated by risk management goals seeking to reduce exposure to compensation claims for which the organisation may be liable. While instigating 'no touch' policies will protect all children, the women are concerned that the same policies may stymie opportunities to nurture seriously at risk children. Discussions reported to be taking place in the Education and Children's Services illustrate this point. There are policy discussions seeking to put into place a no touch policy. This will prevent teachers from using terms of endearment or touching any student. The women can see the rationale behind this thinking, but they are concerned such reactions are based on protecting organisations from liability. They question whether the inability to comfort or touch a young distressed child is in the interests of the child. This woman's story illustrates,

I ran to school every day. I was the first child there. I loved school. I felt cared for there. I sometimes got a hug which I never got at home. I knew there were people who behaved differently than my family and that was my main hope... I wanted to be like the teachers.

Such discussions highlight the need to consider the short and longer term outcomes of any awareness campaign and policy development so they do not diminish possibilities for safe nurture in the desire to protect.

Some key points about campaigns to raise awareness

The women and service providers note a few key points that any public awareness strategy has to consider. These include:

- **The need to provide a help line phone number where people can obtain support on all CSA media awareness campaigns.** There is little point raising awareness if the services cannot provide people with assistance.
- **The target audience for the campaign** needs to be clearly defined and appropriate and accessible language used.
- **All campaigns need to be clear on what they are using as a definition for CSA** because there is disparity regarding definitions and it is contributing to public and professional confusion.
- **Services need to commence accurate data collection with transparent and accessible statistics** that can be provided to one central collection agency each year. Statistics about prevalence of CSA must be based on credible evidence. Media campaigns must have open and transparent sources for their statistical information and definitions. This promotes accountability and trust, and helps the public to realise the statistics are as high as they are reported to be.
- **Think about the impact of media campaigns on survivors.** A comment from a woman participant illustrates, *'When I saw the bus promoting that 1 in 3 women experience CSA, I was even more confused. If there are so many women who have experienced this how come I can't*

cope? I thought I must be a cot case. I felt even more hopeless. There was no point going on because I obviously could not manage, while others could'.

It is important to check media campaigns to see if good intentions may in fact alienate some women who have had different experiences. Public education needs long-term strategies, just as the domestic violence awareness campaigns have taken many years, so will CSA awareness. There is no short way.

- **There needs to be protective behaviours taught in schools** and support for children regarding who is a safe person to tell. Eg school counsellors, chaplains, etc.
- **Use of radio and television** in South Australia in the domestic violence campaigns held in December 2003 had excellent results. There is a great need for ongoing media campaigns, similar to the drink driving and gambling helpline, promotions. The adverts may make people feel uncomfortable, but this discomfort may be what is needed to make people do something about checking these behaviours and getting help.

Good Practice re Seeking Justice

We recognise there are serious attempts being undertaken to alter the judicial system, but the burden of proof still lies with the victim instead of the perpetrator in family violence and CSA cases. This continues to victimise the woman. Many women are unable to withstand the adversarial nature of the scrutiny to which they are subjected. Taylor terms it 'court licensed abuse'⁷¹ and most of the women who have been through the justice system agree. Even those few who secured the conviction of the offending perpetrator, speak of having their identity and confidence shred by the court process. There is definitely a need for reform, but this is the task of other inquiries and beyond the scope of this project. The companion resource for women (Reclaiming Myself After Child Sexual Abuse) was an outcome of this study and provides advice to women about confronting the perpetrator and the judicial system. A second volume by Taylor provides sage advice on how to understand the court system based on researched CSA cases⁷². The sorrowful plea below sums up the feeling of so many women when they are faced with the justice system;

We are the ones that were abused. We are the ones who have had our birthright, to choose who we would share our body and soul with, stolen away from us. We've lost more than our virginity. It was much more than just a sexual act. Yet we are seen as the problem in court. We are discredited and humiliated. We have our integrity questioned and our dignity ripped from us all over again by the courts. It's the ones who are perpetrating that are the problem, yet they are the ones who get believed. They are heard. They continue to get away free and we can continue to carry the shame, when it's not ours to bear. It is really not fair at all. I just don't understand why no one seems to hear us. Don't they want to hear?

The women are adamant that the judicial system needs an overhaul so the victims of family violence are protected. They want more recognition of the ongoing harm done to the child so help is available earlier.

We have been dealing with child sexual abuse as a more visible crime since about 1960 and when you really think about it, how far have we come? When you compare what has been done over 40 years to developments in areas like mental health and addictions, we are still dealing with the old child protection system and it is still not cutting it.

The women say that if professionals could see the linkage between homelessness, addiction and CSA they may understand survivors better and the justice system may provide more appropriate outcomes. The women say they believe the fight for improved justice will get results when there is sufficient community outrage about CSA and less covering up the acts of offending perpetrators. This will only occur when there is better community understanding. Many people who were sexually abused in childhood deal with the impacts for the rest of their lives. This information needs to be recognised by the judicial system so courts set just penalties and obtain more convictions. Interventions may then begin earlier in the trajectory as this woman suggests,

I reckon if a child got someone to come alongside them to encourage them to speak out, say a school counsellor, a chaplain, a school nurse, or someone like that, it would really help. Most kids don't want to be taken away from the family, but they don't want the sexual abuse to go on either. That's what needs to stop. If the child gets support on a daily basis until she is strong enough, she will be able to deal with the future herself. I never got support at home or school, so where could I get it?

Summary

This chapter highlighted a few annotated suggestions for good practice that surfaced from the discussions in the participant groups within this study. The women had specific suggestions about behaviours that facilitated disclosure and the methods for asking about CSA. This chapter explored good practices within the therapeutic relationships and the production of women friendly, safe service environments that allowed them to explore their past. The chapter then focused on good practices in service provision and accessibility of services. It briefly discussed aspects of interactions with the justice system and the importance of raising community awareness about CSA. It highlighted the need for social justice based on community values that disapprove of, and prohibit such offences taking place within families and the broader community. We have deliberately avoided duplicating the excellent information provided in reports by other service providers. We recommend these findings be considered in conjunction with other important research documents that precede it ^{29, 34, 38, 53, 58, 59, 66, 77,}

Chapter 8

Facilitating Transition Via Group Participation



Participation is an essential component to the collaborative research process used within this participatory action research project. Participation is essential to effective group process. Service providers may wish to implement the 'Look, Think, Act' method as a tool to promote problem solving and support group engagement. It is often assumed that because people consent to participate in a group they will become willing and active participants. Facilitation is a taken-for-granted aspect that effects participation in groups and in this chapter we seek to highlight the important issue of creating space for participation. How do you, the worker, enable safe, willing and meaningful participation of all group members when you are dealing with life stories of such a sensitive nature? How do you create the space to work collaboratively so participants' can story and re-story their lives?

The process used in this research was an amalgam of the work of various research theorists²¹⁹,²²⁰ ²⁰, ²²¹, ²²² ²²³, ²²⁴. The working principles guiding group work include relationships, communication and inclusive participation¹⁸. These principles are based on the assumption that each woman is

the self-determining author of her own action, who can and does learn to reflect on her world and her experiences within it. Everyone involved in the group contributes to the collaborative thinking, decision making and idea generating that occurs, which is underpinned by notions of reciprocity and respect for each woman and her self-agency. A person-centred approach is critical to credible group work of all kinds ²²⁵. In group work with vulnerable women we privilege personal empowerment as an aim of all interactions. The process used to create a therapeutic milieu is based on narrative methods that focus on storying lived experiences ^{188, 226-230}.

White and Epston note that people experience problems when the stories of their lives do not represent their lived experiences ²². The narrative approach to group work (discussed in detail in Chapter 1) privileges the person's lived experiences allowing them to tell their story and in so doing externalise the problem/s, separating the issue from the person. The group process enables questions to be raised about the problem/s, examination of the problem that highlight fresh perspectives on the problem/s. In so doing, the woman gains knowledge and power over her problem/s, and a liberating empowerment can ensue as she commences re-storying her life experiences with these alternate understandings.

We noted five key factors helped facilitate participation. These five categories and their contributing features are described using examples from this project. The categories include the:

1. physical space for group meetings;
2. process;
3. facilitator;
4. participants; and
5. group dynamics.

The physical space for group meetings

I really don't like to talk about stuff and I tend to just try and forget about everything, which is what I have always done, so bringing it all out is going to be really difficult. At least I feel safe here (at Catherine House).

When working with women, who may be vulnerable, sensitive and economically disadvantaged, it is important to find a meeting space that is accessible and in a familiar location, so the women feel comfortable in that space. The room should be small, but not confined. It should have comfortable seating that is spaced, with enough room for each woman to move freely while maintaining a distance from her neighbour that she feels is safe. It is important that the women control the space, so seating, heating and

cooling are negotiated because discussing intense experiences in a small room can make people feel uncomfortably closed in. As facilitator you should sit furthest from the door so each woman can feel free to leave if and when she needs to. If there are co-facilitators you should not sit together. There should be tissues and glasses of water available in the room, because sharing painful life stories can bring up emotions that are expressed through tears.

The Process

Participation facilitated by informed consent and transparent processes

Informed consent is ambiguous in group work because the process is participant driven^{231, 232, 233}. This may be true if cooperation is coerced as in court mandated group work, but in our case participation is entirely voluntary²³⁴. To that end, the women are reminded their participation in any group activity has no impact on services available to them. It is important this is clearly understood. A woman can tell as much, or as little, of her story as she wants to within the group. It is important for women with sensitive life stories to have a clear understanding of what is to happen in the group process and to ensure the locus of control stays with them regarding the content of discussions. This means that dialogue can become divergent, and sensitive questioning is required to gently guide the conversation from time to time. Informed consent requires revisiting issues of disclosure, privacy, confidentiality, and control of any data generated, at regular intervals. It is important to reassure, and if possible demonstrate, confidentiality procedures in your practice.

Participation is voluntary

Participation is more likely if participants choose to join a group and give their informed consent to the process. Discuss the possible risks and benefits to the women and invite them to join. At all times during all group work the woman is in control of what she chooses to speak about. In most cases the women 'test the water' to check reactions, before embarking on telling their stories. The women need to know you, and the others, can handle what you are about to hear. Some women need to be reassured that you are genuine about wanting to listen. The women monitor body language closely, so you should be conscious to demonstrate that you are fully present, able and

I left the group because of what was being said and the shock of realising this stuff has happened to me. It took a while for me to realise that. I thought I was all alone in the world, you know. I was the only person this had happened to. I came back because I am ready to talk more about this I think...I've thought, go back and actually go in and sit down and talk about that. My confidence is growing and I can go through with it. Sometimes it's really hard to talk about these things. It's got to come out, but it's really hard to bring it all out.

willing to listen. Recognise the importance of attentive and respectful listening, and allow the woman time to think and freedom to cry. Do not react negatively to the use of any language she uses to describe her life story. She should be free to speak in whatever way that is helpful to tell her story. You can ask some clarifying questions if a woman gets stuck, as this may be helpful for her to move through difficult aspects of her story.

Some women are sceptical that the group process can be empowering. It is helpful to request patience with the process, underscoring your belief in, and experience of, the power of narrative group work, using the 'Look, Think, Act' process, to effect meaningful change. Encourage them to try it. If they are not finding it helpful, they can always leave. In our group more than 75% of each group remained. They agree the therapeutic effect of a supportive group process is helpful. The women's capacity to reflect is facilitated by guided questioning and interaction within the group. Here they can safely externalise their problems by naming them and giving them a voice so they gain new perspectives on issues. What each woman takes from the session, or what changes she instigates in her life, is up to the woman. These are often different for each person, which is liberating for the individual and provides unanticipated joys for the facilitator.

The Facilitator

...to come here today, I had to go through my process of 'Oh, I don't want to leave home – Oh, go on silly'. You know, I have to talk myself out the door. Then as soon as I walk in here, I get all excited and bubbly, so yes, it isn't natural now for me to be isolated. I don't know how I'd feel about knowing it (the group) wasn't here.

Many adult CSA survivors actively repress memories of the events, so they can live and function everyday. They avoid discussion of their experiences because it involves disgusting, humiliating and embarrassing details that are painful to recall ¹³⁴. Their early betrayal and violation make these women suspicious and protective. They have difficulty trusting people; therefore facilitating group work requires provision of a respectful and safe space and facilitation that is honest, authentic and non-judgemental.

The facilitator must be aware of personal values, beliefs and attitudes

The facilitator can enhance participation by displaying a willingness to be involved with both the process and the people. Participants pick up whether you want to be there and are genuinely interested and authentic in your responses. The facilitator should demonstrate genuine empathy or the group will not develop the trust required for effective group work. Respectful listening is critical

as is reciprocal responding, which opens possibilities for co-generative dialogue. It is important to demonstrate warmth, friendliness and compassion in interactions, with the freedom to express emotions via laughter and tears.

Something we found important in facilitating groups dealing with such deep and sensitive experiences is the need for hopefulness. The motivation for participation for many women is the need to find a glimmer of hope that the remainder of their life can be different. Therefore it is significant to highlight hopeful scenarios in the dialogue and celebrate high points such as chosen actions that achieve the desired outcome. Try to finish group interactions in a hopeful state. Thank the women for their collaboration, noting how important each woman is to the group process.

Some weeks everything seems like just a big mess in my head and the group helps me find some peace. I can sort things out in my head. I can listen to how others do things and work things out and I can talk it through. At other times it's nice just to sit back and watch, and listen to other people.

It is important to undertake reflection or introspection of your own values and biases. You should regularly check and challenge yourself to see if your stereotypes and labels may be getting in the way of group dynamics and participation. For example, I stereotypically thought homeless women came from lower socio-economic groups, but this was not so. The women participating in this project came from all social strata and had in common CSA experiences and either alcohol, drug or gambling misuse, or domestic violence experiences which had contributed to their homelessness. It is important to look and think and take action to check the impact of your values on your facilitation, so you can take action to remedy any problems early.

The facilitator needs to be clear about her role and responsibilities

Some experts consider that the facilitator's role in this process is one of helping people understand what they need to change, and how they need to change it, but we disagree^{233, 235}. Facilitators cannot assume to know what each woman needs to change, nor how she should proceed. On the contrary, we believe each person is the author of their own story and only they know what they can do to re-story their life. As facilitator you are an active listener who can help the woman externalise her own story and locate in her story, points of strength from which she may build an alternate plot line, to re-story her current situation. You may uncover a dominant narrative and its effects, and highlight alternate stories of resistance, posing questions to guide the participants' reflection. You cannot suppose to know exactly what needs changing, nor how she should do it. The dialogue in the group illuminates new understandings and the facilitator guides that dialogue without directing it. Each woman chooses her own direction and maintains responsibility and autonomy over her

outcomes. We view this as integral to promoting freedom and empowerment. It reinforces to each woman the facilitator's belief that she can choose appropriate actions. This was a revelatory experience for several participants who had been subjugated all of their lives. They discovered the freedom that came with being proactive, rather than reactive, within their own life, and it was empowering and intrinsically motivating.

I'm with people who have had similar experiences and then I feel less different. I mean, I can feel a connection with somebody here. We can share experiences ...it takes the loneliness out of my world and makes my world seem more normal... I can test ideas and ways of living with others who know what it's like, know where I have been... I feel more sane!

The discussion focuses on illuminating the dominant discourse in the society, or in the local 'street' culture. You should seek to expose the illusory effect of any discourse that diminishes the woman, making her feel 'different'. We explored oppressive discourses, such as conversations dominated by a 'victim' stance of self-absorption and powerlessness. These often begin with 'I can't do...' or 'He did...' or 'I always...' We would highlight the lack of choice such language engenders. Values that trouble you, or the woman, are surfaced in the conversations. Together you focus the woman's thinking toward alternative discourses that are more empowering.

Similarly, conversations around the dominant cultural discourse of normality highlight a perceived intra-psychic divide between a desirable way of living and being in the world - 'how I want to be', versus an undesirable state - 'how I really see myself'. The facilitator guides questions to help the woman identify power relations within situations, and the discourses that make the woman feel different. This is difficult because women have to process contradictory messages. On the one hand they want to release themselves from reactive responses that contribute to alcohol and substance misuse. They want to improve their health and recover their identity, self-worth and personal agency. Yet at the same time participating involves facing painful memories and increases the probability of flashbacks. This client group often has multiple health and social problems that can rapidly overwhelm them with emotions of fear, anger and sadness, creating feelings of guilt, shame, grief, hopelessness, anxiety and confusion. The women speak of 'losing their mind', or 'going crazy'. They feel overwhelmed by the backward and forward movement of looking and thinking within their head. This can become the confusion that triggers panic attacks, anxiety and inability to sleep⁸⁸. Such responses make it imperative that facilitation is careful, so participants do not respond to painful experiences with reactions that place them at risk. The fear driven responses of thinking and reacting without reflecting have enabled these women to survive. This provides relief from suffering. When the woman learns to reflect and choose actions, it stops her becoming locked in the dizzying confusion we termed the 'Look-Think Two Step'. So without careful facilitation group work has the potential to be risky. No one can predict what is going to be said, and some conversations can trigger unexpected responses in women.

The facilitator exposes contradictions and points of tension in the dominant story and the woman's own story, highlighting possible action points. Such insights can be met with varied responses. They are welcomed, disregarded, ignored, or denied, but the choice to action remains with each woman participant. This can prove frustrating as this example shows. One participant was making strident personal growth in her understanding and had chosen to action positive life changes. She was reunited with her adult son and immediately reverted to her old pattern of responding to adversity by using drugs and alcohol, which necessitated her expulsion from her living situation and she returned to living on the streets. This incisive insight came from another participant who said, '*...her new ways are as wobbly as unset jelly, but her old ways are set in concrete. When she needs something solid in her life, her new way of living isn't secure enough yet, so she turns to the way she has managed in the past...*'. Such insights generated in group dialogue underscore that everyone learns life-changing truths from participating in narrative group processes. The woman absented herself for a few weeks; she returned to the group and was welcomed back, attending the group for the remainder of the 18 month process where she continued her healing. As facilitator your disappointment should never be expressed by disapproval, or judgemental attitudes. Such attitudes would prevent participants from returning to the group when they are ready.

The facilitator recognises and checks power constructions

The facilitator needs to recognise that the balance of power is not equal in the group process and locating the locus of power and control is important to quality facilitation. You must be conscious of your own values that can influence your interpretation of what you are hearing. Some life experiences are horrendous and you will find it necessary to suspend emotions of anger and horror that well up within you. Do not be concerned with accuracy, instead recognise that resurfacing traumatic memories causes anxiety and confusion, which sometimes makes detail a bit scrambled, or jumbled. Instead listen for what each woman's story is saying about her feelings and perceptions of her life now.

I don't react any more to what they say, what they do - my mum or my father - and it's given me a new lease on life. I have my own life now. I'm no longer thinking of what they're going to say, or how they're going to react. I won't let them regain that power over me, because now that I know how released I can feel, I won't go back there. I can control that and I will!

The structure of dialogue and language used to create common understanding may have to be negotiated at times, so meaning is clear to all the participants. If words used are not understood, seek clarification. Some of the street language around drugs and the sexual acts of prostitutes had not been heard before within the group, and women sought explanation. Questioning for clarity is important, because it can create alternative awareness and prevent misunderstanding and inaccuracy.

The facilitator requires good communication and interpersonal skills

It is important to have good interpersonal skills for quality participation. A scenario follows: one participant jumps into every conversation. She sometimes cut off other participants preventing them from entering the discussion. This habit is compounded by her victim position, which makes her believe that her story is worse than the experiences of other women. As facilitator, you (and the other participants) can become exasperated by such responses, particularly when the person does not have insight into the ramifications of her behaviour. Such people may not be able to see their actions are dissuading others from participating. It is important that 'worst case scenario discussions' are discouraged, because these conversations increase alienation, decrease participation and diminish personal validation. When a participant wants to offer her opinion/advice on every situation, so that mutual dialogue becomes impossible, participation is in jeopardy. Participants have a low tolerance for such behaviour and they will vote with their feet and leave the group. The conversation will self-destruct into conflict if the facilitator does not check this behaviour quickly and carefully.

To manage such participants, agree together to some group norms regarding equal participation. Have pre-planned strategies to manage the situation within the group. For example inform the participant that the group has heard her perspective and needs to hear from others in the group. Utilise diverting strategies employed in traditional group work. You may meet with her personally and explain that her life story was indeed horrendous, but each woman has a painful story to share. For the group to work effectively, a safe space needs to be created for each woman to give her story words. Some participants need time, and a pause in the conversation provides that time to think through her story. The pause is not an invitation for comment, it's a thinking space. The woman may be upset and feel hurt by the discussion, but you should talk through her feelings and reassure her

Most people that I meet are damaged in some way. I've gone away from trying to meet the perfect person. I just look for someone I can feel positive around and not get pulled down. I believe in myself now. If anyone criticises me, I just think to myself "You're out mate, that's it". I now know what I want out of my life. I know what I need. I know what I need to get, what I want. I can cut off people who are negative, without guilt and fear... but they can still sneak up on me, so I am being careful.

that she is an important and valued group member, but she is an equal participant in the group. Try to negotiate a plan that you both agree upon. We agreed that she would wait until she was invited to speak. I promised her that I would provide her with the opportunity. I then made certain to follow through with that offer. The woman came to the group and apologised for 'hogging the floor'. She began in earnest to listen to others. It was a watershed moment in the group and there was a visible relief in the other participants, with a renewed acceptance of her place in the group. From that point participation became easier to manage. To say confronting participants is enjoyable would be a lie. However, it can be necessary. When confronting is done with sensitivity and commitment to finding a workable solution, it assists mutual participation.

The facilitator provides support

It is the facilitator's role to create a trustworthy space that promotes reflection and interaction, allowing the participant freedom to give expression to her thoughts, feelings and emotions. To accomplish this participants are afforded protection from harm, so support is made available from the service to follow-up particular participants who may be in need. Additionally, we gave a letter to each woman at the outset of the group work explaining to the woman's doctors, psychiatrists and other service providers that she was working through issues of past trauma and abuse within a group and may require additional support. The participants were encouraged to keep an eye on each other and alert the group if they were aware of any woman requiring additional support. In this way a circle of support and care was begun within the group.

The facilitator must have personal support

The facilitator needs to build into her practice, personal and ethical ways of managing vicarious traumatisation. It is a privilege to hear the life stories and experiences of women who have experienced the humiliation, degradation, shame and trauma of sexual abuse in childhood. Some narratives were distressing and they left an aching pain in my chest, and a mental picture that I wanted to erase. Hearing the stories created within me feelings of intense sadness. I was initially questioning my place as a facilitating researcher, wondering 'What right do I have to ask them to revisit these dreadful experiences?' Such internal turmoil surfaced from time to time over the 18 months of group work together. It was managed by time spent looking and thinking about how to focus this emotion to help participants re-story their lives and build their capacity, so that telling their story wasn't wasted ²³⁶. It is important to have someone confidential with whom you can debrief, without sharing participant details. I also employed personal strategies such as meditation, introspection and prayer, as helpful strategies to prevent vicarious traumatisation.

The Participants

Participation is facilitated by the personal motivation of participants

Participants expressed their desire to tell their story, and have it heard by a wider audience as the driving motivation to belong to the group. They wanted their painful past to make a difference for the future. For some their motivation was the hope that talking about their life story would reduce the ongoing impact of prior traumatic experiences.

I am just being a little bit more objective and analytical about things, rather than automatically reacting. It's sort of happening...it's working. Like, it's getting bigger (using look/think/act) the more I use it. I'm a little bit more organised. Then when a situation comes up out of the blue, I am trying to use alternative ways of handling it, than I did before.

Each participant is unique. For example, discussions around sexual behaviour were drawn from participants' different life experiences. These were underpinned with varying personal values and norms. This heightened feelings of difference for some women, and shocked others. As facilitator it was important to remain non-judgemental and turn the focus on the fact abhorrent experiences of sexual abuse in childhood can trigger different reactions in women, but all are valid accounts of their experiences.

Each woman has unique social, communication and problem solving skills that affect her participation. Some women have more self-confidence and self-esteem, and can share freely. Others have pre-existing mental illness, such as dissociative identity disorder, which affects their ability to focus, concentrate and stay engaged in conversations. We found that it helps if the facilitator does not know too much about the participants' medical information. It prevents you from categorising participants according to stereotypes that accompany some of the medical labels assigned to this client group. From time to time a woman may identify her condition and specific behaviours associated with that condition may require different strategies to engage such participants. However, as a general starting point we believe it is more helpful not to know too much medical information about your group participants.

Participation is facilitated by finding a common story among the participants

Participants raise current personal issues and seek clarification from others. They may locate common ground within one another's experiences. It helps if the structure of discussion is loose, so the woman has time to think about what is said, seek clarification, contemplate her experiences, and share them. In so doing she sees aspects of her own story in the narratives of others. Facilitation at this time allows for looking and thinking, even when this moves discussion tangentially. Many participants are not aware of how their thoughts, feelings and attitudes influence their thinking and actioning. They spend some time within the group exploring this, using a current 'problem' scenario. The women find this knowledge (detailed in Chapter 1) enlightening and begin to see that there is a process to problem solving. When it is applied systematically it highlights new ways forward and draws attention to possibilities that the woman may not have considered before. She can then take actions to achieve her hoped for outcomes.

As the participants' confidence grows they use the group to make sense of what is happening in their lives. Unpacking their stories increases their understanding, so they can think about alternative ways to reshape or re-story their situation. The group should be a safe space to discuss stories and locate meaning. The women engage with their situation, using 'Look, Think, Act' to work out what is going on. This produces the tacit knowledge women need to take the actions that create change. Surfacing tacit knowledge is useful because it reinforces the alternate story of survival, resistance, strength and agency. That story line becomes the framework for reshaping a new story. Group conversations provide a forum where women consider their options, contemplate probable consequences and outcomes of various actions, and prioritise future actions. The outcome is often that the situation takes on new meaning, and doing nothing is the chosen action. This is an excellent outcome because the woman is choosing to create space to scope out the terrain of her problem before nominating her chosen action. This is an important alteration from past patterns of responding, which tend to be reactive responses to intense emotions such as fear, anger, guilt and shame.

You've got to be empowered to make decisions and know that it's okay to make mistakes. Because you can make an unhelpful decision and then reverse it, but if you've always had other people controlling you all your life, you haven't had the chance to practise taking and having responsibility for simple things, let alone complex issues, or children. The group empowers me to make better decisions.

I'm less stressed about matters, you know. Like I think the last few weeks I've been pretty calm about everything actually. There's not much that's upset me. I'm channelling my energy to what I want to achieve, not wasting it on useless people or things that lead to the old path. I'm putting the puzzle pieces together with truth and then seeing what picture they make. Then I'm reshaping the pieces and replacing them to create a new future picture that is what the group is helping me do.

The Group Dynamics

When dealing with sensitive issues having a large group is not possible so group size should be limited to about eight participants and facilitator/s. This enables the women to get to know each other and form the trust that facilitates exchange of personal details. Groups should be held in a regular and continuous manner when dealing with such sensitive subject matter. It takes time to establish the trust required to share intimate and personal stories. Look at the current impact of CSA, and then work at changing responses. The groups have been successful and many of the women wanted the group to continue. Some no longer wish to foreground their CSA story. They now feel able to manage their lives without this support, which is a wonderful outcome.

Guidelines for group behaviour should be developed in consultation with the group. Confidentiality is stressed and personal expectations and fears explored. The combined story (presented in Chapter

2) can be used as a starting point for discussion. The women may be surprised and pleased to know they are not alone in their experience. Then invite the women to respond to aspects of the common story and speak to their current life experiences, as they feel comfortable to share. No person is ever coerced to speak and they may decline to say anything, which is not uncommon in the early weeks. Invitations to speak may be met with responses that contribute new understandings and demonstrate to the rest of the group the value of sharing. In our groups several women sat silently within the group for several months before they found the courage to give their story a voice. Some might say these women are not participating. However, some women have had their voice dismissed for so much of their lives, that locating the power to speak is a new skill. If groups are scheduled to take place over short time frames, women such as these may never find their voice. It is wrong to assume that silence equals non-participation. These women were astute at taking from conversations what they wanted to work with in their lives. As workers, we may make assumptions that participation is lacking because people are not speaking. Certainly group dialogue is optimal if one is able to externalise a problem, but dialogue cannot be forced, and its absence does not mean transformative change is not occurring in the mind of the quieter participants.

I blocked it out for 37 years. I know for a fact that it affected a lot of decisions in my life, especially my relationships, and it affected my children too. Since I have been coming to this group my children are back with me now. I have seen the change in them, because they have seen the change in me.

Seeing the links between the sexual abuse and our addiction, and the abuse and our behaviours... linking thoughts and believing that this stuff happened and knowing that it has had an impact on our lives is essential to our healing... we can't keep denying it has an effect. To live free requires a sea change... this programme is helping me see myself and the things that happened differently and I will never be that self-destructive again.

One aspect of group work that is most challenging is the management of unanticipated distress that some participants can experience in the group. The expression of emotions that accompany grief and loss leave a heavy sadness that can envelop the group. This can lead to despair if it is poorly managed. It is difficult to exit meetings at such times and we found it useful to stop discussion if it got too difficult and spend time discussing the validity of safely expressing hurt feelings in the group. It seemed important to validate painful memories, but not to let them overwhelm the woman again. We shared how we felt and what we each could do with those feelings before we closed such meetings. Often a woman would spontaneously get up from her seat to give a distressed woman a hug, or an affirming touch, or say something encouraging. At our early meetings we discussed group norms around personal space and touch, because some women are uncomfortable about touch. However, spontaneous acts of compassion were helpful to the group process and were always met with acceptance from the hurting participant. Therefore, we feel such contact can be appropriate in a safe group. When there was distress in the group we always stressed the availability of professional support and debrief opportunities after the group, for any woman who needed it.

As the group process moves on, the women may begin to ask questions of each other and the facilitator. Such confrontation develops a genuine open relationship, but needs to be delivered sensitively and thoughtfully, so that your responses do not reinforce the dominant story line of the woman as 'different'. It is important to share personal experiences, values and beliefs when these are requested within the conversation. It stops participants feeling as if you are different from them. It helps them know what you think or feel about a situation. Such mutual sharing improves rapport, builds trust and empathy, and assists in co-creating meaning²³⁷. It should never be imposed on participants, but briefly sharing your thoughts when the women want to know something, may be helpful.

Summary

Participation is an essential component of an effective group process that service providers may wish to implement, using the 'Look, Think, Act' method discussed within this resource. Quality facilitation can be learned and we have shared some key aspects that we learned in this study, which will provide the space for participation. This group work with vulnerable women privileges personal empowerment as an aim of all interactions. It uses a therapeutic milieu described in Chapter 3 and creates understanding based on narrative methods that focus on storying lived experiences. We noted that five key factors facilitate participation. They include the physical space for group meetings; the process; the facilitator; the participants; and the group dynamics.

Conclusion

The suffering inherent in the experience of CSA can be turned around. Understanding the impacts of the experiences and allowing someone to help with the healing journey presents a challenge to many women. They want to trust, and most want to reclaim their self-agency. Sharing the story, complete with its accompanying emotions, thoughts and feelings, requires supportive facilitation. When the woman begins to unravel herself from the binding feelings, she experiences a freedom that is empowering and liberating. She may need to retell her story as it evolves over time. With each telling and each hearing, she may transform her suffering into new breaths of life, wisdom and compassion. We hope this book has given you some more helpful practices to facilitate transition.

We have been privileged to journey alongside some wonderful women for the last two years. The last word about the process we used, and where the women are at now, should go to the women.



Everybody hurts sometimes, at different times and in different ways, no one is exempt. However, the choice I have is whether I allow my suffering to propel me forward, to engage me more fully with life and discover its true meaning. Growing through these hurts has helped me to see the value in connecting with others, and ultimately my God. Together we are shaping my future. I have found where I truly belong. For me, there would be nothing worse than to have suffered all this agony in vain, to become bitter, rather than better.

Yes. I like it. I love my life. This is the most favourite time in my life and definitely it's good. I'm the happiest I've been, not because things are going perfect at all, but because I'm living daily with my own issues and sorting them out instead of them controlling me, I am working it out. I'm dealing with all the usual life things that come up for everyone, dying parents, friendships that we start to build upon and then I have to make a decision. It's really neat to be in a position to work things out well. I've got control for once!



I'm not 'going with the flow' as it were, because then you can get caught up with it and go right over the waterfall! I'm steering the course I want to choose. I'm responsible for those choices. I can make them for myself and be responsible for the outcomes too. And even if I make a bad choice, I know that I don't have to stay there. Before I felt I had no way of getting out of it. Now I know how to get out... there are things I can do.



That's it. I know the position I am in now. I can support them. I'm not as strong as I'd like to be, but still I can see why others (people with addiction) gravitate toward me. I'm a link to the better side of life now. Before I was swimming around in the same fish bowl as them, but I can say 'No!' to being involved with them, or their lives.



In my case I numbed myself to stop myself from feeling. The more I was numb the less I felt. When it got to the point that I started feeling things, it got very scary and it made me feel very unsure and insecure, because I was used to numbing everything away. I am grateful that I now have feelings because I feel like a human being. I feel like I am different from what I used to feel like. It is good to

feel and good to be able to feel emotions like pain, or goodness, or laughter. When you have numbed everything out for such a long time it is like opening up a new present, you don't know what will be in it! Feeling numb for me is not an option anymore, I am living life to the fullest and I have more clarity than I have ever had. I am making decisions that move me forward.



It's thirteen years I've been telling my story. Maybe not to the right people all the time, but something has compelled me to tell it and not give up on it, but continue to tell it. I've been punched for it, I've been put down for it, I've been homeless for it, and it's been used against me. I'll still keep telling it and telling it, and I'm going to keep telling it. The more I hear myself say my story, the better I understand myself. The better I understand my story, the better I understand ways that I can deal with it. I get myself stronger, but I can also get angry. So now and then I need to sit back and wait for everything to cool down. That is something I have learned from here. That's it. I Look, I Think and then I Act. It will be my action ... yeah, that's the thing.



References

1. Colton G, Grossman M. *When a Child or Youth is Sexually Abused... A Guide for Youth, Parents and Caregivers. The Handbook*. Vol. 2005. Ontario: Central Agencies Sexual Abuse Treatment Program's (CASAT), 1997. <http://www.casat.on.ca/handindx.htm>
2. White M. *Re-Authoring Lives: Interviews & Essays*. Adelaide: Dulwich Centre Publications, 1995.
3. McGinty S. *Community capacity building*. Australian Association for Research in Education Conference,. Brisbane: School of Indigenous Australian Studies, James Cook University, Townsville QLD, 2002. <http://www.aare.edu.au/02pap/mcg02476.htm> p1
4. Koch T, Marks J, Moss J. *Evaluation of the Collaborative Action Program*. Royal District Nursing Service Research Unit, RDNS Foundation 1999.
5. Koch T. *'Having a say': negotiation in fourth-generation evaluation*. Journal of Advanced Nursing 2000; 31(1):117-125.
6. Alvesson M, Skoldberg K. *Reflexive Methodology*. London: Sage, 2000.
7. Hart E, Bond M. *Action research for health and social care. A guide to practice*. Buckingham: Open University Press, 1995.
8. Koch T, Mann, S., Kralik, van Loon, AM. *Look, think and act cycles in participatory action research*. Journal of Research in Nursing, 2005; 10(3):261-278.
9. Koch T, Mann S, Kralik D, van Loon AM. *Reflection: Look, think and act cycles in participatory research*. Journal of Research in Nursing 2005; 10(3):261-278.
10. Kralik D. *A Participatory Approach to Nursing Research*. International Conference for Community Health Nursing (ICCHNR). London, UK, 2004.
11. Wadsworth Y. *Principles for participatory action research. Extract. Everyday evaluation on the run*. Melbourne Vic: Action research issues association, 1991. pp. 89.
12. Wadsworth Y. *What is participatory action research?* , 1998.
13. Reason P, Bradbury H. *Handbook of Action Research: Participative Inquiry & Practice*. 2004 ed. London, UK: Sage Publications, 2001.
14. Etherington K. *Supervising counsellors who work with survivors of childhood sexual abuse*. Counselling Psychology Quarterly 2000; 13(4):377-393.
15. Saakvitne KW, Pearlman LA. *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. New York.: W W Norton and Co, 1995.
16. Stringer E. *Action Research*, 2nd Edition. California: Sage Publications, 1999.
17. Stringer E. *Action Research*. California: Sage Publications, 1996.

18. Stringer E, Genet WJ. *Action Research in Health*. New Jersey USA: Pearson Education Inc, 2004.
19. Stufflebeam DL. *The CIPP model for program evaluation, in Evaluation models: viewpoints on education and human resources evaluation, (eds). In Madaus GS SM, Stufflebeam DL, ed. Boston, USA: Kluwer-Nijhoff, Hingham, 1973. pp. 117-141.*
20. Koch T. *Collaborative evaluation research*. Chapter 16. *In Schneider Z, Elliott D, LoBiondo-Wood G, Haber J, eds. Nursing Research: Methods, critical appraisal and utilisation. Sydney: elsevier (Australia) Pty Limited, 2003. pp. 233-245.*
21. Matthieson CS, H. *Negotiating identity with cancer narratives*. *Sociology of Health and Illness* 1995; 17(3):283-306.
22. White M, Epston D. *Narrative means to therapeutic ends*. New York: WW. Norton & Co., 1990.
23. Kelly M. *Self identity and radical surgery*. *Sociology of Health and Illness* 1992; 14(3):390-415.
24. Banks-Wallace J. *Emancipatory Potential of Storytelling in a Group*. *IMAGE: Journal of Nursing Scholarship* 1998; 30(1):17-21.
25. Bird J. *The Heart's Narrative: Therapy and Navigating Life's Contradictions*. Auckland: Edge Press, 2000.
26. Nelson HL. *Damaged Identities, Narrative Repair*. Ithaca: Cornell University Press, 2001.
27. Bauer JJ, McAdams DP. *Personal growth in adults' stories of life transitions*. *Journal of Personality*. 2004; 72(3):573-602.
28. Dulwich Centre. *Working with the stories of women's lives*. Adelaide: Dulwich Centre Publications, 2001.
29. Dulwich Centre. *Responding to Violence: A collection of papers relating to child sexual abuse and violence in intimate relationships*. Adelaide: Dulwich Centre Publications, 2003.
30. Russell S, Carey M. *Narrative Therapy: Responding to your Questions*. Adelaide: Dulwich Centre Publications, 2004.
31. White C, Denborough D. *Introducing narrative therapy: A collection of practice based writings*. Adelaide: Dulwich Centre Publications, Adelaide, 1998.
32. Saxe BJ. *From Victim to Survivor: A Group Treatment Model for Women Survivors of Incest*. Vol. 2004. Canada, 1993. <http://www.hc-sc.gc.ca>
33. Mathews F. *Combining Voices: Supporting Paths of Healing in Adult Female and Male Survivors of Sexual Abuse*. Cat. No.: H72-21/137-1995E. Ontario: Family Violence Prevention Unit of Health Canada, 1995.
34. Holden T. *It's Still Not My Shame*. Women's Health Statewide 2002.
35. Barnes PD. *The woman inside: A resource guide to lead women from incest victim to survivor*. Ketchikan, Alaska, USA: Mother Courage Press, 1989.

36. Davis L. *The Courage to Heal Workbook: For women and men survivors of child sexual abuse*. Santa Cruz CA: Harper Perennial, 1990.
37. King R. *We Could Fly. Improving Services For Adult Survivors of Childhood Sexual Abuse in Rural South Australia*. Murray Mallee Community Health Service 1998.
38. Brown A. *Abuse, Ramifications and Recovery*. Townsville: Aanee Brown Enterprises, 2003.
39. Plummer CA. *Prevention is appropriate, prevention is successful*. In Gelles RJ, Loseke DR, (eds). *Current Controversies on Family Violence*. Newbury Park, California: Sage Publications, 1993.
40. Tower CC. *Understanding Child Abuse and Neglect*. Boston: Allyn & Bacon, 1989.
41. Tomison AN. *Update on Child Sexual Abuse- No 5, Summer 1995*. Issues in Child Abuse Prevention. Canberra: National Child Protection Clearinghouse, 1995.
42. Kempe CH, Silverman, F.N., Steele, B.F., Droegemuller, W. and Silver. *The battered child syndrome*. *Journal of the American Medical Association* 1962; 18(1):17-24.
43. Reppucci N, Haugaard J. *Problems with child sexual abuse prevention programs*. In Gelles R.J and Loseke DR (eds) *Current Controversies on Family Violence*. Newbury Park, California: Sage Publications, 1993.
44. Korbin JE. *Child sexual abuse: a cross-cultural view*. In Oates RK, (ed) *Understanding and Managing Child Sexual Abuse*. Sydney: Harcourt Brace Jovanovich, 1990.
45. Finkelhor D. *Child Sexual Abuse: New Theory & Research*. New York: Free Press, 1984.
46. ABS. *Sexual Assault in Australia: A Statistical Overview*. Australian Bureau of Statistics 2004. accessed August 2005 <http://www.abs.gov.au/Ausstats/abs@.nsf/Lookup/FBA1483A3660DA40CA256F070079CBD2>
47. ABS. *Recorded crime : victims, Australia 2003*. Australian Bureau of Statistics 2004. <http://www.abs.gov.au/Ausstats/abs@.nsf/Lookup/84B8736E23196511CA2570280078B4F6>
48. ABS. *Recorded crime : victims, Australia 2004*. Australian Bureau of Statistics 2005. <http://www.abs.gov.au/Ausstats/abs@.nsf/Lookup/1659F460CBE3D884CA25688800283A7D>
49. Haugaard J. *The Challenge of Defining Child Sexual Abuse*. *American Psychologist* 2000; 55(9):1036–1039.
50. Herman J. *Trauma and recovery*. New York: Basic Books, 1992.
51. Rokvic D. *Betrayal of trust: the experiences of adult women victim/ survivors of child sexual assault*. 8th Australian Institute of Family Studies Conference. Melbourne: Australian Institute of Family Studies, 2003. <http://www.aifs.gov.au/institute/afrc8/rokvic.pdf>
52. AIHW. *A Picture of Australia's Children*. Australian Institute of Health and Welfare 2005.
53. AIHW. *Child protection Australia 2003–04*. Australian Institute of Health and Welfare 2005.
54. Angus GW, S. *Child abuse and neglect Australia 1993-94*. Australian Institute of Health and Welfare AGPS, 1995.

55. Fullerton CS, Ursano RJ. *Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster*. Washington D.C: American Psychiatric Press Inc. 1997.
56. Schachter C, Stalker C, Teram E. *Handbook on Sensitive Practice for Health Professionals – Lessons from Women Survivors of Childhood Sexual Abuse*. Ontario Canada: National Clearinghouse on Family Violence, Family Violence Prevention Unit Health Canada, 2001.
57. Mullighan E. *Children in State Care: Commission of Inquiry Interim Report*. 2005.
58. Eastwood C, Patton W. *The Experiences Of Child Complainants Of Sexual Abuse In The Criminal Justice System*. Queensland University of Technology 2003.
59. Attorney General's Department. *Young People and Domestic Violence: National research on young people's attitudes and experiences of domestic violence*. Commonwealth Government of Australia. 2001.
60. ABS. *Recorded crime : victims, Australia 2002*. Australian Bureau of Statistics 2003. <http://www.aic.gov.au/publications/facts/2003/fig024.html>
61. Wood BL. *Prevalence of childhood sexual abuse in a community sample of Australian women*. Medical Journal of Australia 1997; 166(12):667.
62. Goldman R, Goldman JT. *The prevalence and nature of child sexual abuse in Australia*. Australian Journal of Sex Marriage and Family 1988; 9:94-106.
63. Fleming JM. *Prevalence of childhood sexual abuse in a community sample of Australian women 1997*. Medical Journal of Australia 1997; 166:65-68.
64. Fergusson DM, Mullen PE. *The prevalence of sexual abuse during childhood Chapter 2. Childhood sexual abuse. An evidence based perspective*. Thousand Oaks, CA: Sage, 1999.
65. Fergusson DM, Lynskey MT, Horwood LJ. *Childhood sexual abuse and psychiatric disorders in young adulthood: Part I: The prevalence of sexual abuse and the factors associated with sexual abuse*. Journal of the American Academy of Child and Adolescent Psychiatry 1996; 35:1355 - 1365.
66. ABS. *Women's safety survey*. Australian Bureau of Statistics 1996. <http://www.abs.gov.au/ausstats/abs@.nsf/0/B62DEB3A2574CA2568A900139340?Open>
67. James M. *Child abuse and neglect: Part one – redefining the issues*. Australian Institute of Criminology 2000.
68. Layton R. *Child protection review report: Our best investment: A state plan to protect and advance the interests of children*. Government of South Australia. 2003. www.dfc.sa.gov.au/childprotectionreview/cpr-report.asp
69. The Royal Women's Hospital CASA House. *Sexual Assault - Statistics*. Vol. 2005. Sydney: CASA House The Centre Against Sexual Assault, 2004.

70. Kerr D. *Legally Abused: The Child Sexual Assault Victim In The Adult Criminal Court*. Child Sexual Abuse: Justice Response or Alternative Resolution Conference. Adelaide: Australian Institute of Criminology, 2003.
71. Taylor S. *Court Licensed Abuse: Patriarchal lore and the legal response to intrafamilial sexual abuse of children*. New York: Peter Lang Publishing Inc., 2004a.
72. Taylor S. *Surviving the legal system: A handbook for adult and child sexual assault survivors and their supporters*. Pt Melbourne: Coulomb Communications, 2004b.
73. Gordon S, Hallahan K, Henry D. *Putting the picture together, inquiry into response by government agencies to complaints of family violence and child abuse in Aboriginal communities*. Department of Premier and Cabinet 2002.
74. Stanley J, Cadd M, Pocock J. *Child sexual abuse in Indigenous communities*. Vol. 1. Adelaide: National Child Protection Clearinghouse, 2003. pp. 1-9.
75. Department of Indigenous Affairs. *Breaking the silence on sexual abuse: 'My body belongs to me': an awareness-raising project for Aboriginal communities*. Department of Indigenous Affairs 2002.
76. Cossins A. *Saints, sluts and sexual assault: rethinking the relationship between sex, race and gender*. Social and Legal Studies 2003:77-103.
77. Western Australian State Government. *Putting people first: the Western Australian State Government's action plan for addressing family violence and child abuse in Aboriginal communities*. Western Australian State Government 2002.
78. Browne A, Finkelhor D. *Impact of child sexual abuse: a review of the research*. Psychological Bulletin 1986; 99:66 - 77.
79. Beitchman JH, Zucker KJ, Hood JE, et al. *A review of the short-term effects of child sexual abuse*. Child Abuse and Neglect 1991; 15:537 - 556.
80. Beitchman JH, Zucker KJ, Hood JE, et al. *A review of the long-term effects of child sexual abuse*. Child Abuse and Neglect 1992; 16:101 - 118.
81. Bushnell JA, Wells JE, Oakley-Browne M. *Long-term effects of intrafamilial sexual abuse in childhood*. Acta Psychiatrica Scandinavica 1992; 85:136 - 142.
82. Scott D, Walker, L. and Gilmore, K. *Breaking the Silence: A Guide to supporting adult victim/survivors of sexual assault*. Melbourne: Centre Against Sexual Assault, Royal Women's Hospital. 1995.
83. Astbury J, Atkinson J, Duke JE, al. e. *The impact of domestic violence on individuals*. Medical Journal of Australia 2000; 173:427-431.
84. Cook BD, F. and Grant, A. *Sexual violence in Australia*. Australian Institute of Criminology 2001. <http://www.casat.on.ca/handindx.htm>

85. Mullen PE, Fleming J. *Long-term Effects of Child Sexual Abuse Issues*. Child Abuse Prevention 1998; 9(Autumn1998).
86. Stojadinovic T. *For the first time somebody wants to hear: the effects of childhood sexual abuse on women's experiences of pregnancy, birth and mothering*. Women's Health Statewide 2003.
87. Perry BD. *Neurobiological sequelae of childhood trauma: post-traumatic stress disorders in children*. In Murburg M, ed. *Catecholamine function in post-traumatic stress disorder: emerging concepts*. Washington, DC: American Psychiatric Press, 1994.
88. Quas JA, Goodman GS, Jones D. *Predictors of attributions of self-blame and internalizing behavior problems in sexually abused children*. Journal of Child Psychology & Psychiatry & Allied Disciplines 2003; 44(5):723-736.
89. Fergusson DM, Horwood LJ, Lynskey MT. *Childhood sexual abuse and psychiatric disorders in young adulthood: Part II: Psychiatric outcomes of sexual abuse*. Journal of the American Academy of Child and Adolescent Psychiatry 1996; 35:1365 - 1374.
90. Briere JN. *Child Abuse - the Lasting Effects: Trauma and Treatment*. California: Sage, 1992.
91. Bebbington PE, Bhugra D, Brugha T, et al. *Psychosis, victimisation and childhood disadvantage: Evidence from the second British National Survey of Psychiatric Morbidity*. [Article]. British Journal of Psychiatry September 2004; 185:220-226.
92. Tyler KA, Whitbeck LB, Hoyt DR, Johnson KD. *Self-Mutilation and Homeless Youth: The Role of Family Abuse, Street Experiences, and Mental Disorders*. [Article]. Journal of Research on Adolescence December 2003; 13(4):457-474.
93. Spataro J, Mullen PE, Burgess PM, et al. *Impact of child sexual abuse on mental health: Prospective study in males and females*. [Article]. British Journal of Psychiatry May 2004; 184:416-421.
94. Schumm JA, Hobfoll SE, Keogh NJ. *Revictimization and Interpersonal Resource Loss Predicts PTSD Among Women in Substance-Use Treatment*. [Article]. Journal of Traumatic Stress April 2004; 17(2):173-181.
95. Miller BA. *Victimization and drug abuse: Gender, addiction and women*. Washington, D.C: Presented at Smithsonian Institute, 2000.
96. Miller BA, Downs WR, Tesla M. *Interrelationships between victimization experiences and women's alcohol use*. Journal of Studies into Alcohol Supplement 1993; 11:109-17.
97. Logan TK, Walker R, Cole J, Leukefeld C. *Victimization and substance abuse among women: Contributing factors interventions and implications*. Review of General Psychology 2002; 6(4):325-397.
98. Fergusson DM, Horwood LJ, Lynskey MT. *Childhood sexual abuse, adolescent sexual behaviours and sexual revictimization*. Child Abuse and Neglect. 1997; 21:789 - 803.

99. Briere J, Runtz M. *Differential adult symptomatologies associated with three types of child abuse histories*. Child Abuse and Neglect 1990; 14:357 - 364.
100. van der Kolk BA. *The Body Keeps the Score: Approaches to the psychobiology of posttraumatic stress disorder*. In B. A. van der Kolk, A. C. McFarlane, L. Weisaith (Eds.), eds. Traumatic Stress. The Effects of Overwhelming Experiences on Mind, Body, and Society. New York: The Guilford Press., 1996. pp. 214–241.
101. Radomsky NA. *Lost Voices: Women, Chronic Pain and Abuse*. New York: Harrington Park Press., 1995.
102. Golding JM, Wilsnack SC, Learman LA. *Prevalence of sexual assault history among women with common gynecologic symptoms*. American Journal of Obstetrics & Gynecology 1998; 179(4):1013-1019.
103. Eonseca BK, Booth S. *Child Sexual Assault and the Prevalence of Sexually Transmitted Diseases*. Journal of Paediatrics & Child Health 1997; 33(4):45.
104. Lundqvist G, Hansson K, Svedin CG. *The influence of childhood sexual abuse factors on women's health*. [Article]. Nordic Journal of Psychiatry 2004; 58(5):395-401.
105. Widom CS, Weiler BL, Cottler L. *Childhood victimization and drug abuse: a comparison of prospective and retrospective findings*. Journal of Consulting and Clinical Psychology 1999; 67(6):9867-880.
106. Wilshaw G. *Perspectives on surviving childhood sexual abuse*. [Miscellaneous]. Journal of Advanced Nursing August 1999; 30(2):303-309.
107. Ullman SE, Brecklin LR. *Sexual Assault History and Health-Related Outcomes in a National Sample of Women*. Psychology of Women Quarterly 2003; 27(1):46-57.
108. Hyman SM, Gold SN, Cott MA. *Forms of Social Support That Moderate PTSD in Childhood Sexual Abuse Survivors*. [Article]. Journal of Family Violence October 2003; 18(5):295-300.
109. Reeves RB, D. Killu, K. *Implications of Traumatic Brain Injury for Survivors of Sexual Abuse: A Preliminary Report of Findings*. Rehabilitation Psychology 2000; 45(2):205-211.
110. Bolen RM. *Extrafamilial Child Sexual Abuse: A Study of Perpetrator Characteristics and Implications for Prevention*. Violence Against Women 2000; 6(10):1137-1169.
111. Cole PM, Putnam FW. *Effect of incest on self and social functioning: a developmental psychopathology perspective*. Journal of Consulting and Clinical Psychology 1992; 60:174 - 184.
112. Rind B, Tromovitch P, Bauserman R. *Psychological Bulletin*, 1998; 124:22–53.
113. Rind B, Tromovitch P. *A meta-analytic review of findings from national samples on psychological correlates of child sexual abuse*. Journal of Sex Research 1997; 34:237-255.
114. Ondersma SJ, Chaffin M, Berliner L, et al. *Sex with children is abuse: Comment on Rind, Tromovitch, and Bauserman* (1998). Psychological Bulletin 2001; 127:707-714.

115. Lilienfeld SO. *When worlds collide: Social science, politics, and the Rind et al. (1998) child sexual abuse meta-analysis*. *American Psychologist* 2002; 57:176-188.
116. Emery CL, Lilienfeld SO. *The Validity of Childhood Sexual Abuse Checklists in the Popular Psychology Literature: A Barnum Effect?* [Miscellaneous]. *Professional Psychology Research & Practice* June 2004; 35(3):268-274.
117. van der Kolk BA. *The Body Keeps the Score: Memory and the Evolving Psychobiology of Posttraumatic Stress*. Boston.: Harvard Medical School, 1994.
118. Rothschild B. *The Body Remembers - The Psychophysiology of Trauma and Trauma Treatment*. New York: W.W. Norton & Company, 2000.
119. Wright JK. *Trauma, the Body and Transformation: a Narrative Inquiry*. [Book or Media Review]. *British Journal of Guidance & Counselling* May 2004; 32(2):257-258.
120. Joy M, Hall R. *Appropriate Service Responses to Assist Young People Who have Experienced Sexual Abuse*. CASA 1998.
121. Martin R. *Is this homelessness? Women and children affected by domestic and family violence*. 3rd National Homelessness Conference 'Beyond the Divide' convened by the Australian Federation of Homelessness Organisations, 6-8 April 2003. Brisbane: Department of Social Work and Social Policy, Curtin University of Technology, 2003.
122. Brown J, Cohen P, Chen H, et al. *Sexual Trajectories of Abused and Neglected Youths*. [Article]. *Journal of Developmental & Behavioral Pediatrics* April 2004; 25(2):77-82.
123. Chung D, Kennedy R, O'Brien B, Wendt S. *Home Safe Home*. Social Policy Research Group, University of South Australia. 2000. http://www.padv.dpmc.gov.au/oswpdf/wesnet_report.pdf
124. The NSW Women's Refuge Movement and the Victorian Council to Homeless Persons. *Out of the Fire: Domestic Violence & Homelessness*. DVIRC, Domestic Violence & Incest Resource Centre 2001.
125. Macmartin C. *Judicial Constructions of the Seriousness of Child Sexual Abuse*. [Article]. *Canadian Journal of Behavioural Science* January 2004; 36(1):66-80.
126. Arata CM. *Child Sexual Abuse and Sexual Revictimization*. *Clinical Psychology: Science & Practice* 2002; 9(2):135-164.
127. Gladstone GL, Parker GB, Mitchell PB, et al. *Implications of Childhood Trauma for Depressed Women: An Analysis of Pathways From Childhood Sexual Abuse to Deliberate Self-Harm and Revictimization*. [Article]. *American Journal of Psychiatry* August 2004; 161(8):1417-1425.
128. Sadoff RL. *From Child Sexual Abuse to Adult Sexual Risk: Trauma, Revictimization, and Intervention*. [Book or Media Review]. *American Journal of Psychiatry* June 2004; 161(6):1142-1143.
129. Eastaer P. *Less than equal: Women and the Australian legal system*. Sydney: Butterworths, 2001.

130. Briggs F. *Every school's worst nightmare: child sexual abuse*. 2005 AW Jones Oration. Adelaide, SA: University of Adelaide, 2005.
131. Gravestock F. *Cost of child abuse and neglect in Australia, 2001-2002*. Child Abuse and Neglect Summit. Barton, ACT: Families Australia, 2004.
132. State Government of Victoria. *It happened to us women talk about child sexual abuse*. 3rd Edition,. Vol. June Reprint. Melbourne: Child Protection and Care, Community Care Division, Victorian Government Department of Human Services, 2000.
133. Farrell LT. *Factors that affect a victim's self-disclosure in father/daughter incest*. Child Welfare 1988; 5:463 - 468.
134. Mazza D, Dennerstein L, Garamszegi CG, Dudley EC. *The physical, sexual and emotional violence history of middle-aged women: a community-based prevalence study*. Medical Journal of Australia 2001; 175:199-201.
135. Martin J, Anderson J, Romans S, et al. *Asking about child sexual abuse: methodological implications of a two-stage survey*. Child Abuse Neglect 1993; 17(3):383-392.
136. Jones JL, Whitworth JM. *Emergency Evaluation and Treatment of the Sexual Assault Victim*. Topics in Emergency Medicine 2002; 24(4):47-61.
137. Harrington B, Cullen P. *Disclosure of child sexual abuse*. BMJ 1998; 317(7152):208-.
138. Fredrickson R. *Repressed memories: A journey to recovery from sexual abuse*. New York: Simon and Schuster, 1992.
139. Courtois C. *The memory retrieval process in incest survivor therapy*. Journal of Child Sexual Abuse 1992; 1:15-31.
140. Loftus EF, Garry, Maryanne., Feldman, Julie. *Forgetting Sexual Trauma: What Does It Mean When 38% Forget?* [Special Feature]. Journal of Consulting and Clinical Psychology 1994; 62(6): 1177-1181.
141. McNally RJ. *Remembering trauma*. Cambridge, MA: Harvard University Press., 2003.
142. Brown D, Schefflin AW, Hammond DC. *Memory, trauma treatment, and the law*. New York: Norton, 1998.
143. Pope KS. *Memory, abuse, and science: Questioning claims about the false memory syndrome epidemic*. American Psychologist 1996; 51:957-974.
144. Williams LM. *Recall of childhood trauma: A prospective study of women's memories of child sexual abuse*. Journal of Consulting and Clinical Psychology, 1994; 62:1167-1176.
145. Waymire V. *A triggering time: childbirth may recall sexual abuse memories*. MIDIRS Midwifery Digest 1997; 7(3):337-339.
146. Bradley AR. *How do children tell? The disclosure process in child sexual abuse*. El Paso, TX.: University of Texas at El Paso, 1995.

147. Arata CM. *To Tell or Not To Tell: Current Functioning of Child Sexual Abuse Survivors Who Disclosed Their Victimization*. *Child Maltreatment* 1998; 3(1):63-.
148. Lovett BB. *Child Sexual Abuse Disclosure: Maternal Response and Other Variables Impacting the Victim*. [Article]. *Child & Adolescent Social Work Journal* August 2004; 21(4):355-371.
149. Elliott AN, Carnes CN. *Reactions of Non offending Parents to the Sexual Abuse of Their Child: A Review of the Literature*. *Child Maltreat* 2001; 6(4):314-331.
150. Jonzon E, Lindblad F. *Disclosure, Reactions, and Social Support: Findings from a Sample of Adult Victims of Child Sexual Abuse*. *Child Maltreat* 2004; 9(2):190-200.
151. Brown A, Young, Marion. *Beyond the Lies*. Townsville: Aaneee Brown Enterprises, 2000.
152. Mullen PE, Martin JL, Anderson JC, et al. *The long-term impact of the physical, emotional and sexual abuse of children: a community study*. *Child Abuse and Neglect* 1996; 20:pp. 7 - 22.
153. Breckenridge JLL. *Challenging Silence: Innovative Responses to Sexual Abuse and Domestic Violence*. St. Leonards, NSW.: Allen and Unwin., 1999.
154. Sanders C. *A Long Road Home- Working with Adult Survivors of Child Sexual Abuse from a Systemic Perspective*. *Australian & New Zealand Journal of Family Therapy* 1992; 13(1):16-25.
155. Smallbone S, Wortley R. *Child sexual abuse: offender characteristics and modus operandi I*. Australian Institute of Criminology 2001.
156. Australian Bureau of Statistics. *Women's Safety Australia Survey*. 1996.
157. Morris RE, Anderson MM, W KG. *Incarcerated adolescents' experiences as perpetrators of sexual assault*. *Archives of Pediatrics and Adolescent Medicine* 2002; 156(8):831-835.
158. Prentky R, Knight R, Lee A. *Child Sexual Molestation: Research Issues*. Office of Justice Programs, US Dept of Justice, 1997.
159. Itzin C. *Incest, paedophilia, pornography, and prostitution: making familial males more visible as the abusers*. *Child Abuse Review* 2001; 10:35-48.
160. Howells K, Day A, Wright S. *Affect, Emotions and Sex Offending*. [Article]. *Psychology, Crime & Law* June 2004; 10(2):179-195.
161. Wurtele SK, Miller-Perrin CL. *Preventing Child Sexual Abuse: Sharing the Responsibility*. Lincoln: University of Nebraska Press, 1993.
162. Bell K. *Female offenders of sexual assault*. *Journal of Emergency Nursing* 1999; 25(3):241-243.
163. Fitzroy L. *Violent women: Questions for feminist theory practice and policy*. *Critical social policy* 2001; 21(21):7-34.
164. Australian Institute of Health and Welfare (AIHW). *Child Protection Australia*. Australian Institute of Health and Welfare. 2000.
165. Freer M, Seymour S. *The abyss of despair: South Australian Women's experiences of child sexual abuse*. *Women's Health Statewide* 2003.

166. Beckett C. *Child protection: An introduction*. SAGE Publications: London, 2003.
167. Women's Health Statewide. *It's not my shame: the adult survivors of child sexual abuse working party report*. Women's Health Statewide 1994.
168. Health Department of Western Australia. *Family and domestic violence training package Participants' Kit*. 2003. Perth: Health Department of Western Australia, 1997. <http://www.health.wa.gov.au/directory/index.cfm?char=F>
169. Department of Human Services. *It happened to us: Women talk about child sexual abuse*. 3rd edition. Melbourne Victoria: Child Protection and Care, Community Care Division, Victorian Government Department of Human Services, 2000.
170. Domestic Violence & Incest Resource Centre (DVIRC). *Identifying Family Violence: A Resource Kit for General Practitioners in the Western Suburbs of Melbourne (VIC)*. Domestic Violence & Incest Resource Centre (DVIRC) 2000.
171. The Canadian Women's Health Network. *Suggestions for Physicians and Primary Care Nurses: A Resource for Women Survivors of Abuse and their Health Care Providers*, 2004. Canada.
172. The Canadian Women's Health Network. *Survivors and the Health Care Encounter: A Resource for Women Survivors of Abuse and their Health Care Providers*.
173. Domestic Violence & Incest Resource Centre (DVIRC). *Identifying family violence: A resource kit for general practitioners in the western suburbs of Melbourne*. In West WH, ed. *Identifying Family Violence*, Vol. 2003. Melbourne: Partnerships Against Domestic Violence, 1999.
174. Department of Human Services. *It happened to us: Men talk about child sexual abuse 3rd edition*. Melbourne Victoria: Child Protection and Care, Community Care Division, Victorian Government Department of Human Services, 2000.
175. Caddick B. *Using Groups in Working with Offenders: A Survey of Groupwork in the Probation Services of England and Wales*. Groupwork 1991.
176. Canaris C. *The 'out of house' solution to boundary violations*. [Miscellaneous]. *Australasian Psychiatry* December 2003; 11(4):406-409.
177. Jones M, Mordecai M, Rutter F, Thomas L. *The Miskin Model of Groupwork with Women Offenders*. Groupwork 1991.
178. Domestic Violence Prevention Unit W. *Best practice model for the provision of programs for perpetrators of domestic violence in Western Australia*. Domestic Violence Prevention Unit 2000.
179. Toman P. *Ethical Issues In The Treatment Of Child Sex Offenders: A Tightrope Walk Over a Precipice of Paradox*. Child Sexual Abuse: Justice Response or Alternative Resolution Conference. Adelaide: Australian Institute of Criminology, 2003.
180. Laing L. *A different balance altogether? Incest offenders in treatment*. In Breckenridge JL, Laing, L (eds). *Challenging Silence: innovative responses to sexual and domestic violence*. Sydney: Allen & Unwin, 1999.

181. Herman J. *Recovery from psychological trauma*. Psychiatry and Clinical Neurosciences 1997; 52(s5):145-156.
182. Verco J. *Women's outrage and the pressure to forgive: Working with survivors of child sexual abuse*. The International Journal of Narrative Therapy and Community Work. 2002; 1:23-27.
183. Hyman B, Williams L. *Resilience Among Women Survivors of Child Sexual Abuse*. Affilia 2001; 16(2):198-219.
184. *Silent Too Long. Your Voices Inspire Mine*. Dulwich Centre Journal 1998; 4.
185. Alexander PC. *The differential effects of abuse characteristics and attachment in the prediction of long-term effects of sexual abuse*. Journal of Interpersonal Violence 1993; 8:346 - 362.
186. Crossley ML. *Introducing Narrative Psychology: Self, Trauma and the Construction of Meaning*. Buckingham: Open University Press, 2000.
187. Taylor C. *Sources of the Self: The Making of Modern Identity*. Cambridge: Cambridge University Press, 1989.
188. Becker G. *Disrupted Lives: How People Create Meaning on a Chaotic World*. Berkeley: University of California Press, 1997.
189. Ruf F. *Postmodern Pilgrimage: In Quest of the Disrupted Self*. Vol. 2005. Georgetown: Georgetown University, 2003.
190. Winkler KP. *Locke on Personal Identity*. In Chappell V, ed. Locke. Oxford: Oxford University Press, 1988.
191. Lowe EJ. *Locke on Human Understanding*. London: Routledge, 1971.
192. Freud S. *Introductory Lectures on Psychoanalysis*. London: George Allen and Unwin Ltd, 1921.
193. Paterson B. *The shifting perspectives model of chronic illness*. Journal of Nursing Scholarship 2001; 33(1):21-26.
194. Frank A. *Why study people's stories? The dialogical ethics of narrative analysis*. International Journal of Qualitative Methods 2002; 1(1).
195. Bauman Z. *Liquid modernity*. London: Polity Press, 2000.
196. Frank AW. *Survivorship as Craft and Conviction: Reflections on Research in Progress*. Qualitative Health Research 2003; 13(2):247-255.
197. Stringer ET. *Action Research 2nd Edition*. California: Sage Publications, 1999.
198. Van Loon AM. *Creating a conceptual model of faith community nursing in Australia using participatory action research*. Faculty of Health Sciences. Adelaide, South Australia: Flinders University. 2000. pp. 360.
199. Chinn P, Kramer D. *Theory and Nursing, Integrated Knowledge Development*. 5th ed. ed. Missouri: Mosby, 1999.
200. Bridges W. *Transitions: Making sense of life's changes*. Cambridge, MA: Da Capo Press, 2004.

201. O'Leary PJ. *Working with Men Suffering from Childhood Sexual Abuse*. Adelaide Central Mission 2002.
202. Tucker-Ladd C. *Psychological Self help*. Vol. 2005: Mental Health Net, 2000. <http://mentalhelp.net/psyhelp/>
203. Linnell S, Cora D. *Discoveries a group resource guide for women who have been sexually abused in childhood*. Sydney: Dympha House Publications, 1993.
204. van Gennep A. *The Rites of Passage*. Chicago: University of Chicago Press, 1960.
205. Turner V. *The Ritual Process*. Ithaca. New York: Cornell University Press, 1969.
206. Selder F. *Life Transition theory: The Resolution of Uncertainty*. Nursing & Health Care 1989; 10(8):437-451.
207. Saldana J. *Ethnodrama: An Anthology of Reality Theatre*. Walnut Creek, CA: AltaMira Press, 2005.
208. Meleis AI, Sawyer LM, et al. *Experiencing Transitions: An Emerging Middle-Range Theory*. Advances in Nursing Science 2000; 23(1):12-28.
209. Young-Eisendrath P. *The Resilient Spirit: Transforming Suffering into Insight and Renewal*. Westwood MA, USA: Da Capo Press, 1996.
210. Angelica JC. *We are not alone: a guidebook for helping professionals and parents supporting adolescent victims of sexual abuse*. New York: J Haworth Maltreatment and Trauma Press, 2002.
211. Astbury J, Atkinson J, Duke JE, et al. *The impact of domestic violence on individuals*. Medical Journal of Australia 2000; 173(8):427-431.
212. Blagg H, Ray D, Murray R, Macarthy E. *Crisis intervention in Aboriginal family violence: summary report*. Crime Research Centre, University of Western Australia 2000.
213. Boyle M. *Men, Male Family Violence and Homelessness*. 2001.
214. Clayton K. *Domestic Violence - private matter or public health issue*. Emergency Nursing News- Royal College of Nursing, RCN Accident and Emergency Association 2001(Spring):1-8.
215. Crime Prevention Committee - Parliament of Victoria. *Combating Child Sexual Assault: An Integrated Model, First Report*. Government Printer 1995.
216. Dal Grande E, Hickling J, Taylor A, Woolacott T. *Domestic Violence in South Australia: a population survey of males and females*. Australian and New Zealand Journal of Public Health. 2003; 27(5):477-576.
217. Dalton C, Gottlieb L. *The concept of readiness*. Journal of Advanced Nursing 2003; 42(2):108-117.
218. Dunne MP, Purdie DM, Cook MD, et al. *Is child sexual abuse declining? Evidence from a population-based survey of men and women in Australia*. Child Abuse & Neglect 2003; 27(2):141-152.

219. Stringer ET. *Principles of Community-Based Action Research. Action Research: A Handbook for Practitioners*. Thousand Oaks: Sage Publications, 1996.
220. Stringer ET. *Action research: A handbook for practitioners*. Thousand Oaks, California: Sage publications, 1996.
221. Koch T. *Story telling: is it really research?* Journal of Advanced Nursing 1998; 28(6):1182-1190.
222. Koch T. *Look, Think and Act - Guiding a participatory approach to inquiry*. Collaborative Conversations Conference. Bournemouth, UK, 2003.
223. Reason P, Bradbury H. *Handbook of Action Research*: Sage Publications, 2001.
224. Reason P. *Justice Sustainability, and participation*. Concepts and Transformations 2002; 7(1):7-29.
225. McCormack B. *Researching nursing practice: does person-centredness matter?* 1. [Article]. Nursing Philosophy October 2003; 4(3):179-188.
226. White M. *Re-Authoring Lives: Interviews & Essays*. Adelaide: Dulwich Centre Publications, 1998.
227. Gergen K. *The saturated self: Dilemmas of Identity in contemporary life*. New York: Basic, 1991.
228. Kleinman A. *The illness narratives: suffering and the human condition*. New York: Basic books Inc., 1988.
229. Nettleton S, Watson J. *The body in everyday life: an introduction*. In Nettleton S, Watson J, eds. *The Body in Everyday Life*. New York: Aspen Publication, 1998. pp. 1-24.
230. Brody H. *Stories of Sickness*. Second ed. New York: Oxford University Press, 2003.
231. Williamson G, Prosser S. *Illustrating the ethical dimensions of action research*. [Miscellaneous Article]. Nurse Researcher Ethics in Research 2002; 10(2):38-49.
232. Meyer JE. *New paradigm research in practice: the trials and tribulations of action research*. Journal of Advanced Nursing 1993; 18:1066-1072.
233. Meyer J. *Using qualitative methods in health related action research* . [Miscellaneous Article]. BMJ January 2000; 320(7228):178-181.
234. Williams A. *Ethics and action research*. [Miscellaneous]. Nurse Researcher March 1995; 2(3):49-59.
235. Harvey GB, Loftus-Hills A, Rycroft-Malone J, et al. *Getting evidence into practice: the role and function of facilitation*. [Miscellaneous Article]. Journal of Advanced Nursing March 2002; 37(6):577-588.
236. Webb C, Turton P, Pontin D. *Action Research - Chapter 15*. In Roe B, Webb C, eds. *Research and Development in Clinical Nursing Practice*. London: Whurr Publishers Ltd, 1998. pp. 290-311.
237. Soltis-Jarrett V. *The Facilitator in Participatory Action Research: Les raisons d'être*. [Miscellaneous]. Advances in Nursing Science December 1997; 20(2):45-54.



Support Service Phone Details

The following list of services is an abbreviated sample of some of the South Australian groups that women CSA survivors may want to access for counselling, information, courses, accommodation and other support organisations to assist them on their healing journey.

For a complete list of services please see your White Pages Telephone Directory under the Business & Government Listing. These phone numbers were correct at July 2005. They are not a comprehensive directory. Phone numbers do change from time to time, so if a number doesn't work, please check the telephone directory, or find the agency at *Infosearch* <http://www.infosearchweb.com/>.

Crisis Services

Ambulance, Fire and Police (emergency and life threatening service): 000

Crisis Care (4pm-9am Mon-Fri and 24 hours on public hols): 13 1611

Domestic Violence Crisis Service (Accommodation): 1300 782 200

Lifeline: 13 1114 [in South East Mt Gambier 13 1611]

Mental Health 24hour crisis service: 13 1465 outside metro area: 1800 182 232

Police to attend: 11444

Rape and Sexual Assault Service 24 hour emergency line: 8226 8787

Sexual Assault Crisis Line: 1800 806 292

Help Lines

Abortion Grief Counselling: 1300 363 550

Advocates for Survivors of Child Abuse: 1300 657 447

Al-Anon/Alateen Families of Alcoholics: 8231 2959

Alcohol and Drug Information Services (24 hour Counselling): 1300 131 340

AIDS Council of SA: Freecall ™ 1800 888 559 (Free from fixed Telstra line)

Anglicare: Emergency Assistance: 1800 061 551

Child Abuse Report Line (24 Hour): 13 1478

Child Support Action Group (non custodial parent support line): 8341 1225

Domestic Violence Helpline: Freecall ™ 1800 800 098 (Free from fixed Telstra line)

Drug-Arm Australia: 1300 656 800

Emergency Accommodation Services SA: Freecall ™ 1800 003 308

Family Drug Support: 1300 368 186

Gambling Helpline 'Break Even' Network: (24 hours) Freecall 1800 060 757

Kids Helpline: 1800 55 1800 (Free from fixed Telstra line)

Medicines Line: 1300 888 763 (local call cost)

Men's Line Australia: 1300 789 978

Mission Australia Helpline: 1300 886 999

Parent Helpline (24 Hour): 1300 364 100

Poisons Information Centre: 13 1126

Pregnancy Helpline (National): 1300 139 313

Respond SA, Adult Childhood Sexual Abuse Helpline: 1800 176 900

SANE Mental Illness Helpline: Freecall ™: 1900 688 382 (Free from fixed line)

Sexual Health Hotline: 8364 0444 (country callers only); 1800 188 171

Suicide Prevention Medical Specialist Information: 1300 360 980

Teen Challenge Suicide Helpline: 1800 771 777

Toughlove South Australia (parent support line): 1300 365 494

Translating and Interpreting Services: 13 1450

Vietnam Veterans Counselling Service (Vet Line): 1800 011 046; Health Line: 13000 131 719

Violence Against Women – 'Australia Says No' (24 hours helpline): 1800 200 526

Women's Healthline: 1300 882 880

Indigenous Specific Services

Aboriginal Family Support Services: 8212 1112

Aboriginal Hostels: 8267 4222

Aboriginal Housing Authority: 8235 4333

Aboriginal Sobriety Group: 8223 4204

Aboriginal and Torres Strait Islander Service: Freecall TM1800 079 098

Nunkuarrin Yunti (health service): 8223 5011

Nunga Mi:Minar Women's & Children's Shelter (Accommodation): 1300 782 200

Weena Mooga Gu Gudba Inc. (Ceduna): 8625 2183 DV Worker: 0428 726 653

Social Support

Abuse Prevention Programme (for >65 years): 8232 5377

Adelaide Day Centre for Homeless: 8232 0048

Adelaide Diocesan AIDS Council: 8234 9180

Addiction Counselling Service: 8334 3333

Advocates for Survivors of Child Abuse (Mt Gambier): 8725 9308

Alcoholics Anonymous: 8346 3255

AIDS Council of South Australia: 8334 1611 or 1800 888 559

Anglicare SA (Magdalene Centre- Day Centre) 8305 9370 full list in White Pages

Archway Rehabilitation & Community Services: 8305 9650 Sobering Up: 8447 7811

Baptist Community Services (Support Services): 8357 1755 full list in White Pages

Centacare Catholic Family Services (CSA Counselling): 8210 8200; 1800 812 300 full list in White Pages.

Child Abuse Prevention Services: Freecall 1800 688 009 (Free from fixed Telstra line)

Child Adolescent Mental Health Service: Northern 8161 7389; Eastern 8207 8999; Southern 8204 5412; Seaford 8326 1234; see list in White Pages for country

CLAN (Care Leavers of Australia Network): 18000 008 774 or NSW Phone no 9709 4502

Community Health Centre (Counselling) Aboriginal Health 8182 9206; 8243 5611 Northern Women's 8252 3711; Southern Women's 8384 9555; Pt Adelaide 8240 9611; Inner Southern 8277 2488; Noarlunga (CSA) 8384 9555; Migrant 8237 3900 Parks (CSA) 8243 5611, 8243 5612 full list in White Pages

COPE: (Counselling) Library: 8245 8100. Bookshop: 8245 8111

Dale Street Women's Health Centre (CSA Counselling): 8444 0700

Department for Families and Communities: Enquiries: 8226 8800

Dulwich Centre: (Counselling) 8223 3966

Eating Disorders Association: 8212 1644

Emergency Accommodation Services SA (Accommodation): 1800 003 308

Exodus Youth Service: (Youth Counselling): 8356 6999

Family and Youth Services (Information): full list White Pages 8226 6735

Gambling Addiction Treatment Services: 8267 6069

Hills Fleurieu Women's Health Team (Mt Barker: CSA Counselling): 8393 1833

Hutt Street Centre (Counselling, Day Centre, Meals): 8223 2068

Living Hope (Counselling): 8277 4033

Lutheran Counselling & Welfare Centre: 8269 1935

Marion Youth Centre (CSA Counselling): 8377 1055

Mary Street – Adolescent Sexual Abuse Prevention Programme: 8340 4422

Mediation Services: 8350 0376

Men's Information and Support Centre (Counselling): 8212 0331

Mental Health Resource Centre: 8221 5166 full list in White Pages

Mental Illness Fellowship: 8410 5249; 8221 5160

Migrant Health Service: 8237 3900 full list in White Pages

Migrant Women's Support & Accommodation Service Inc. (MWSAS): 8346 9417

Narcotics Anonymous: 8231 4233

Northern Violence Intervention Programme: 8396 1345

Parents Supporting Parents Flag (Gay/Lesbian service): 8241 0616 or 8269 0718

Playford Primary Health Care Services (CSA Counselling): 8252 9900

Poisons Information Centre: 13 1126

Port Augusta Regional Women's & Children's Support Service (Counselling & Accommodation up to 2 months): 8642 4357; AH.1800 655 716, 0428 326 529

Pregnancy Support 'Genesis': 8281 5312

Pregnancy Support 'Birthline': 8331 1223

Pregnancy Counselling (Termination Counselling): 1300 737 732

Relationships Australia (CSA Counselling) Clients: 8223 4566, 1800 182 325.

Respond SA, Adult Childhood Sexual Abuse Services (CSA Counselling): 8419 2000

Riverland Domestic Violence Unit Inc. (Accommodation & Counselling): 8582 2100.

Salvation Army (Emergency Relief): 8227 0199; 8379 9388 full list in White Pages.

Service to Youth Council (Accommodation & Counselling): 8211 8466

Sexual Abuse Support Service, Christies Beach: 8382 3554

Sexual Crime Investigation Branch: 8207 5800

Sexual Offenders Treatment Assessment Program: 8362 3022

Sexually Transmitted Diseases (Clinic 275): Freecall 1800 806 490

Side Street (Youth CSA Counselling): 8202 5871

South Eastern Women's Emergency Services: Freecall TM 1800 631 385

Southern Domestic Violence Service Inc. (Accomm. & Counselling): 8382 0066

Southern Junction Community Services Inc.(Youth CSA Counselling): 8382 3554

Spark Resource Centre Inc. (Pregnancy and CSA Counselling): 8226 2500

Streetlink Youth Health Service (Drug and Alcohol Counselling): 8231 4844

Teen Challenge (Counselling): 8287 1685; 1300 889 288

UnitingCare Wesley Bowden Inc. (Drug and Alcohol Counselling): 8245 7100

UnitingCare Wesley (Counselling and support services): 8202 5111 see White Pages

Warranilla (Drug & Alcohol Detox Unit): 8130 7500, 1300 131 340

Western Domestic Violence Service Inc. (Counselling & Accomm.): 8268 7700

Women's Health Statewide (CSA Counselling): 8239 9600

Women's Housing Association Inc (Accommodation >18yrs): 8349 4460

Youth Health Services (the Second Story) (CSA Counselling): 8232 0233



Helpful Contacts

Contact details for the South Australian services that assisted in this project:

Addiction Counselling Services

Highgate Building

103 Fisher Street, Fullarton, S.A. 5063

Hours: 9am to 5pm Monday to Friday

Phone: 08 8334 3333

Website: www.addictioncounsellingservices.com.au

Alcoholics Anonymous

18 Third Street, Brompton, S.A. 5007

Hours: 9.30am – 4.30pm Monday to Friday

Phone: 08 8346 4004; 08 8346 3255 (A.H.)

Email: csoaasa@picknowl.com.au

Website: csoaasa.cjb.net

Baptist Community Services

35 King William Road, Unley, S.A. 5061

Hours: 9am to 5pm Monday to Friday

Phone: 08 8357 1755; 1800 045 004

Email: westcare@sabaptist.asn.au

Website: www.sabaptist.asn.au/bcs

Catherine House Inc.

PO Box 6031, Halifax Street, Adelaide S.A. 5000

Hours: 9am to 5pm Monday to Friday

Phone: 08 8232 2282

Email: admin@catherinehouse.org.au

Website: www.catherinehouse.org.au

Centacare, Catholic Family Services

33 Wakefield Street, Adelaide, S.A. 5000

Hours: 9am to 5pm Monday to Friday

Phone: 08 8210 8200, 1800 812 300

Email: cfs@centacare.org.au

Website: www.centacare.org.au

Dale Street Women's Community Health Centre

47 Dale Street, Port Adelaide, S.A. 5015

Hours: 9am to 5pm Monday to Friday

Phone: 08 8444 0700

Website: www.whs.sa.gov.au/services_dale.php

Domestic Violence Crisis Service

PO Box 6578, Halifax Street, Adelaide, S.A. 5000

Hours: 9am – 5pm Monday to Friday

Phone: 08 8413 8121

Helpline: 1300 782 200 24 hrs, 7 days

After Hours Crisis Care: 131 611

Domestic Violence Helpline

Hours: 24 hours, 7 days a week

Phone: 1800 800 098

Website: www.ucwesleyadelaide.org.au/domesticviolence

Drug & Alcohol Services South Australia (DASSA)

Hours: 24 hours, 7 days a week

Phone: 1300 13 13 40 – toll free

Gambling Helpline: 1800 060 757

Email: dassa@saugov.sa.gov.au

Website: www.dassa.sa.gov.au

Dulwich Centre

Hutt Street PO Box 7192, Adelaide, S.A. 5000

Hours: by appointment

Phone: 08 8223 3966

Email: dulwich@senet.com.au

Website: www.dulwichcentre.com.au

Gambling Addiction Treatment Services

6-8 Walter Street, North Adelaide, S.A. 5006

Hours: 9am to 10pm 7 days a week

Phone: 08 8267 6069 (7 days, 24 hours)

Email: gats5@lycos.com

Website: www.gatscounselling.com

Mission Australia Hindmarsh Centre

35 Richard Street, Hindmarsh, S.A. 5007

Sobering Up Unit

Hours: 5pm to 9.30am 7 days a week

Outreach Programme

Hours: 9am to 5pm Monday to Friday

Phone: 08 8346 4015

Website: www.missionaustralia.com.au

Offenders Aid and Rehabilitation Services of SA Inc

231 Morphett Street, Adelaide, S.A. 5000

Phone: 08 8218 0700

Hours: 9am to 5pm Monday to Friday

Email: oars@oars.org.au

Website: www.oars.org.au

Ramsay Health Care

SA Mental Health Services

Note: Private Health Cover Required

Website: www.ramsayhealth.com.au

The Adelaide Clinic

33 Park Terrace, Gilberton, S.A. 5081

Hours: 24 hours, 7 days per week

Phone: 08 8269 8100

Fullarton Private Hospital

293-295 Fullarton Road, Parkside, S.A. 5063

Hours: 24 hours, 7 days per week

Phone: 08 8272 0233

Kahlyn Day Centre

40 Briant Road, Magill, S.A. 5072

Hours: 8am to 4pm, Monday to Friday

Phone: 08 8331 0811

Relationships Australia (SA)

55 Hutt Street, Adelaide, S.A. 5000

Hours: 9am to 5pm Monday to Friday

9am to 9pm Tues, Wed and Thurs

Phone: 08 8223 4566 or 1300 364 277

Country Clients Free Call 1800 182 325

Email: mail@rasa.org.au

Website: www.relationships.com.au

Respond SA: Adult CSA Counselling

Phone: 08 8419 2000

Salvation Army Social Service

39 Florence Street, Fullarton, S.A. 5063

Hours: 8.30am – 4.45pm Monday to Friday

Phone: 08 8379 9388

Website: www.salvationarmy.org.au/sa

Service to Youth Council Inc

Youth Agency

Adelaide: 72 and 80 Currie Street

Woodville: 65 Woodville Road

Elizabeth East: 10 Saratoga Road

Hours: 9am to 5pm Monday to Friday

Phone: 08 8211 8466, 08 8408 1313, 08 8282 0129

Email: youthagency@syc.asn.au

Website: www.syc.net.au

SHine SA Inc

17 Phillips Street, Kensington, S.A. 5068

Hours: 9am to 5pm Monday to Friday

Phone: 08 8431 5177

08 8364 5033 (appointments)

Email: info@shinesa.org.au

Website: www.shinesa.org.au

Sidestreet Counselling Service

14 Pitt St, Adelaide, S.A. 5000

Hours: 9am – 5pm Monday to Friday

Phone: 08 8202 5871

Email: sidestreet@ucwesleyadelaide.org.au

Website: www.ucwesleyadelaide.org.au

Southern Junction Community Service

13 McKinna Road, Christie Downs, S.A. 5164

Hours: 9am to 5pm Monday to Friday

Phone: 08 8382 3554, 1800 807 364

Residential care: 08 8384 7321 (24 hours)

Email: admin@southernjunction.org.au

Website: southernjunction.org.au

Southern Women's Community Health Centre

Alexander Kelly Drive, Noarlunga Centre, S.A. 5168

Hours: 9am to 5pm Monday to Friday

Phone: 08 8384 9555

Website: http://www.whs.sa.gov.au/services_swhealth.php

Streetlink Youth Health Service

27 Gresham Street (1st Floor), Adelaide, S.A. 5000

Hours: 1.30 to 4.30pm, Mon, Tues, Thurs, Fri

Phone: 08 8231 4844

Email: streetlink@ucwesleyadelaide.org.au

Website: www.ucwesleyadelaide.org.au

The Second Story Youth Health Service

(Division of Children Youth and Women's Health Service)

Adelaide: 57 Hyde Street

(Hours extended to 7pm Friday)

Christies Beach: 50A Beach Road

Elizabeth: 6 Gillingham Road

Hours: 9am to 5pm Monday to Friday

Phone: 1300 131 719

Website: www.cyh.com

UnitingCare Wesley Adelaide

10 Pitt Street, Adelaide, S.A. 5000

Hours: 9am to 5pm Monday to Friday

(Thurs. evenings by appointment)

Phone: 08 8202 5190

Email: enquiries@ucwesleyadelaide.org.au

Website: www.ucwadel.org.au

Women's Health Statewide

64 Pennington Terrace, North Adelaide, S.A. 5006

Hours: 9am to 5pm Monday to Friday

Phone: 1300 882 880 (cost of local call)

1800 128 098 (toll free)

Email: info@whs.sa.gov.au

Website: www.whs.sa.gov.au

Yarrow Place Rape and Sexual Assault Service

Level 2, Norwich Centre,

55 King William Road, North Adelaide, S.A. 5006

Hours: 9am to 5pm Monday to Friday

Phone: 08 8226 8777, 1800 817 421.

After hours and emergency: 08 8226 8787

Email: yarrowplc@mail.wch.sa.gov.au

Website: www.yarrowplace.sa.gov.au

Useful Websites

The following are a few of the many useful websites with information and support resources for CSA survivors. Each site will have many additional links to resources that can assist you in caring for this client group.

Adult Survivors of Child Abuse (Australia): national Australian support organisation

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

American Bar Association Commission on Domestic Violence (USA): a guide to prevent a perpetrator finding out sites you have been visiting on the Internet

<http://www.abanet.org/domviol/internet.html>

Australian Centre for the Study of Sexual Assault (Australia): research, information and links

<http://www.aifs.gov.au/acssa/>

Australian Domestic and Family Violence Clearinghouse (Australia): research and resources on domestic violence in Australia (many links)

<http://www.austdvclearinghouse.unsw.edu.au>

Australasian Legal Information Institute (Australia): legal information

<http://www.austlii.edu.au>

Beyond Blue (Australia): national Australian Commonwealth initiative on depression (mental health links):

<http://www.beyondblue.org.au/index.aspx>

Broken Rites (Australia): A non-denominational support group for people abused in religious institutions.
<http://brokenrites.alphalink.com.au/index.html>

Bursting the Bubble (Australia): Website for children who have been abused: resources and links
<http://www.burstingthebubble.com/>

Centres Against Sexual Assault (Australia): many resources and links
<http://www.casa.org.au/>

Care Leavers of Australia Network (CLAN): for people who have lived in care
<http://www.clan.org.au/> or email support@clan.org.au

Create Foundation: for young people in care situations
<http://www.create.org.au/>

Department for Families and Communities (Australia): Gambling self help book from
http://www.familiesandcommunities.sa.gov.au/DesktopModules/SSSA_Documents/LinkClick.aspx?tabid=104&mid=550&table=SSSA_Documents&field=ItemID&id=94&link=H%3a%5cUploads%5cgambling-help-book.pdf

Domestic Violence & Incest Resource Centre (Australia): many resources and links
<http://www.dvirc.org.au/index.html>

Family Violence Prevention Unit of Health Canada (Canada): many resources and links
http://www.hc-sc.gc.ca/hppb/familyviolence/html/nfntsxvox_e.html

Information on Survivor Flashbacks (USA): survivor page
<http://www.alltheseyears.net/flashbacks.htm>

Mayumarri: retreat and short courses for CSA survivors
<http://www.mayumarri.com.au/>

Men Against Sexual Assault (Australia): Information and links.
<http://www.borderlands.org.au/MASA/>

Mental Health Network (USA): comprehensive self help text on web

<http://www.mentalhelp.net/psyhelp/>

National Campaign Against Violence and Crime (Australia): Commonwealth Government

violence prevention reports and programmes, database of programmes for adolescents.

<http://www.ncavac.gov.au/>

Office of the Status of Women (Australia): *Is Domestic Violence Too Close to Home?*

A kit for rural women (services in each state).

<http://www.dpmc.gov.au/osw/ruralwom.htm>

Pandora's Box (USA): many resources and links about CSA

<http://www.prevent-abuse-now.com/index.htm>

Psychological self help (USA): on-line self help book for mental health

<http://mentalhelp.net/psyhelp/>

Recover Canada Wellness Network (Canada): chat group and resources

<http://www.vansondesign.com/RecoveryCanada/SAResources.html>

Recovered Memories (USA): clinical psychologist run site with resources and links

<http://www.jimhopper.com/memory/>

Rosalie's Story (Australia): survivor story and resources

<http://www.fox.net.au/~woody/rosalie.html>

SHOUT (Support, Heal, Overcome, Understand and Triumph over sexual abuse) **(Australia):**

on-line chat site for survivors.

<http://www.young-earth.com.au/innerv/>

Sibling Abuse (Australia): resources

<http://www.saf.au.tt>

South Eastern Centre Against Sexual Assault (Australia): survivor resources

<http://www.secasa.com.au/survivors/index.html>

South Australian government child protection report (Australia): keeping them safe

www.familiesandcommunities.sa.gov.au/Default.aspx?tabid=95

Survivors on the Net (UK): <http://www.survivors.org.uk/> Australian branch

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

The Canadian Women's Health Network (Canada): information and resources

http://www.cwhn.ca/resources/csa/ab_parenting.html

The Morris Center (USA): many resources and links

<http://www.ascasupport.org/2801a-resources.htm>



Royal District Nursing Service (RDNS)

Foundation of SA Inc.



Catherine House Inc.



AER

Foundation Ltd

Alcohol Education & Rehabilitation Foundation Ltd.

Facilitating Transition



Fac

ans

Facilitating Transition



Royal District Nursing Service
(RDNS) Foundation of SA Inc



Alcohol Education &
Rehabilitation Foundation Limited



Catherine House Inc