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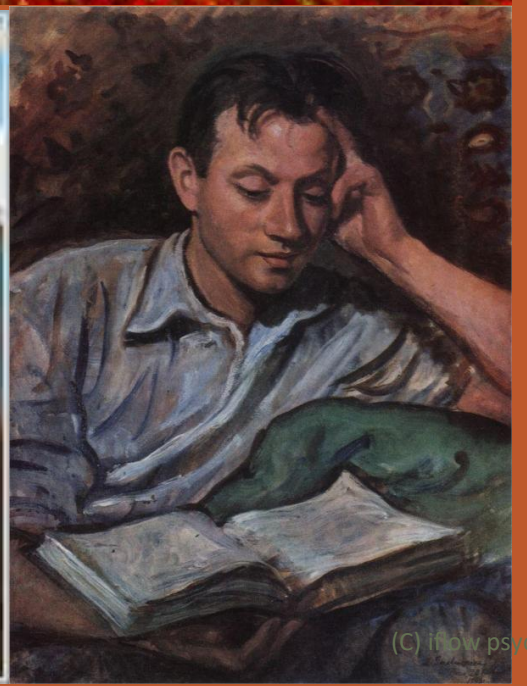
Healing the Hurt

THE REDRESS SCHEME AND VICARIOUS TRAUMA

What do these subjects have in common?

SUBJECTS:

- A pet dog,
- A rabbit,
- Faith, and
- Reading a book.



Overview

1. The Royal Commission into Institutionalised Responses to Child Sexual Abuse: Summary of Findings.
2. The Redress Scheme
3. Neurobiology of Trauma
4. Supporting Clients
5. Trauma-informed Practice (TIP)
6. Effects and Impacts on Workers
7. Care Strategies

My Background

- Senior Psychologist - NSW Police – Joint Investigative Response Teams – that investigated serious and serial sex crimes,

- Counselling Psychologist – NSW Department of Community Services – Governance – Allegations Against Employees and Child Deaths, and

- Counselling Psychologist/Director – iflow psychology – Providing therapeutic psychological counselling services to clients, including those with a history of sexual abuse, some of which was institutionalised abuse.

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Royal Commission into Institutional Responses to Child Sexual Abuse

The Royal Commission into Institutionalised Responses to Child Sexual Abuse:

Summary of Findings

Introduction

The **Royal Commission into Institutional Responses to Child Sexual Abuse (RC)** was established in 2013.

It's purpose was to inquire into and report on responses by institutions to instances and allegations of child sexual abuse in Australia.

The RC was established to investigate allegations that:

- People accused of child abuse were being moved instead of their abuse and crimes being reported, and
- Institutions were failing to prevent acts of child abuse.

The final report of the RC was made public on 15 December 2017.

The RC's understanding of child sexual abuse is based on the information gathered through public hearings, private sessions, research, written accounts, roundtables, public consultations, and issues papers.

What is child sexual abuse?

The RC adopted a broad definition of child sexual abuse:

- *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. Sexually abusive behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, exhibitionism, and exposing the child to or involving the child in pornography. It includes child grooming, which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child's inhibitions in preparation for sexual activity with the child.*

The production, consumption, dissemination and exchange of child sexual exploitation material is also considered to be a form of child sexual abuse.

Who provided information?

In private sessions up to 31 May 2017, the RC heard from:

- 6,875 survivors of child sexual abuse in institutional contexts, and
- Their family members, carers and supporters, and
- Other children in institutions where the abuse took place.

People were not asked to describe the abuse they experienced. Information was drawn from feedback volunteered, such as:

- The abuse,
- The institution in which it occurred,
- The person who carried out the abuse,
- How the institution responded, and
- The impact on them as children and throughout their adult lives.

The survivors participating came from diverse backgrounds and contexts.

Some Findings

Characteristic	Percentage (%)
Majority of those reporting abuse were males	64.3
Aboriginal and Torres Strait Islander people	14.3
Culturally or linguistically diverse backgrounds	3.1
Participated in private sessions while in prison	10.4
Reported they had a disability at time of abuse	4.3
Experienced multiple episodes of child sexual abuse	85
Sexually abused for between two and five years	36.4

- More than half of those who reported their age at the time of abuse were aged between 10 and 14 years when they were first sexually abused,
- 93.8% reported sexual abuse by a male. Consistent with research, which indicates the majority of perpetrators of child sexual abuse across all settings are male.

Nature of Reported Abuse

Child sexual abuse has many different forms.

- Each victim's experience is unique, although common themes emerged including:

Nature of Reported Abuse	%
Non-penetrative, including: • Someone touching their body in a sexual way, or • Being forced to touch someone else's body.	72.6
Penetrative abuse	55.5
Privacy violated	23.9
Groomed for sexual contact	22.8

- Exposure to sexual acts and material,
- Witnessing the sexual abuse of others.
- Most survivors reported experiencing other abuse leading up to, during and/or after the sexual abuse, such as emotional abuse (80.7 per cent) and/or physical abuse (64.4 per cent).

Contributing Factors

Ignorance about child sexual abuse in institutions:

- Hindered prevention and identification, resulting in institutions failing to respond appropriately, and
- Enabled sexual abuse to continue undetected.

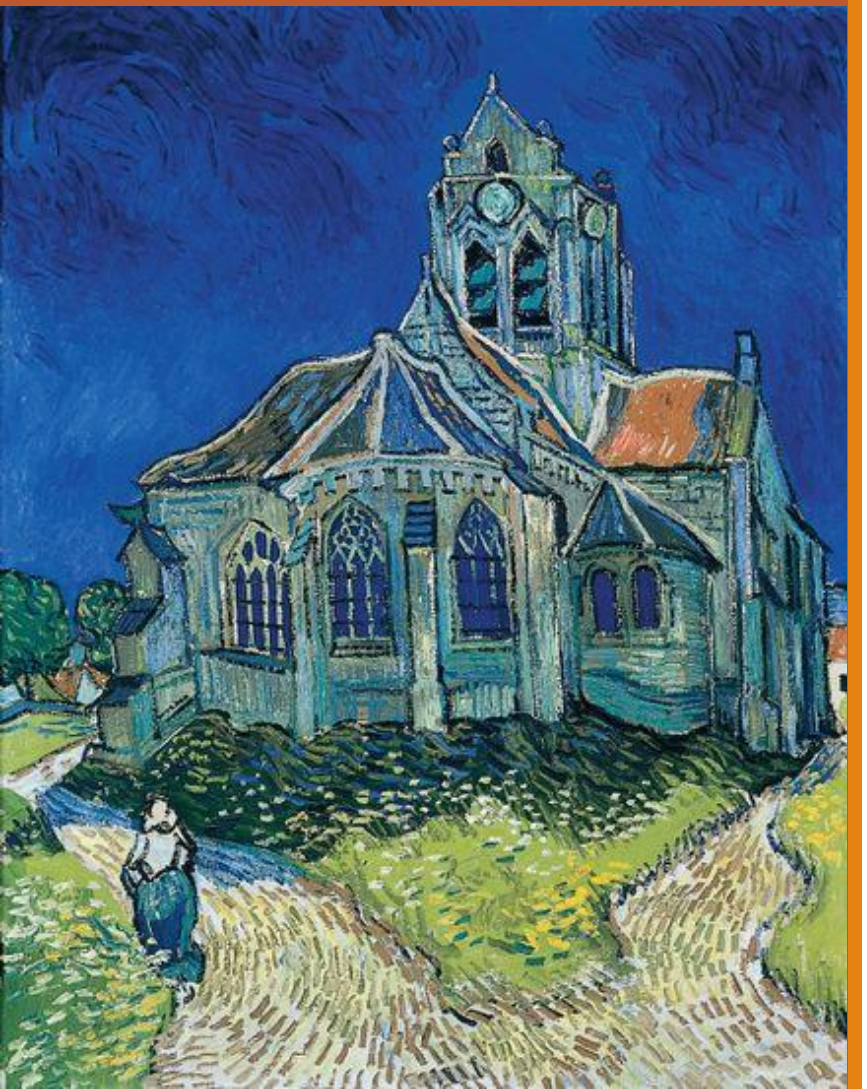
Misconceptions and stigma associated with child sexual abuse prevented:

- Disclosure of abuse,
- Help seeking for support and treatment,

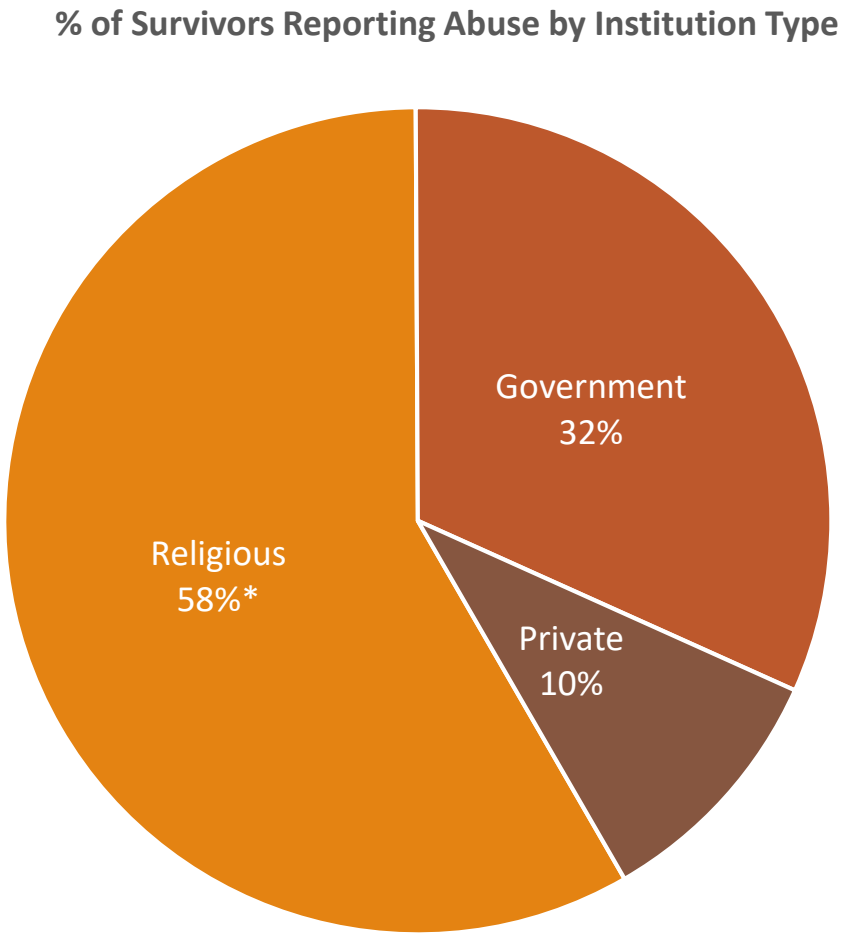
Understanding the problem is essential to:

- Identify and prevent child sexual abuse,
- Enable appropriate support for those affected, and
- Hold to account those who commit, facilitate or conceal abuse.

Abuse by Institution Type



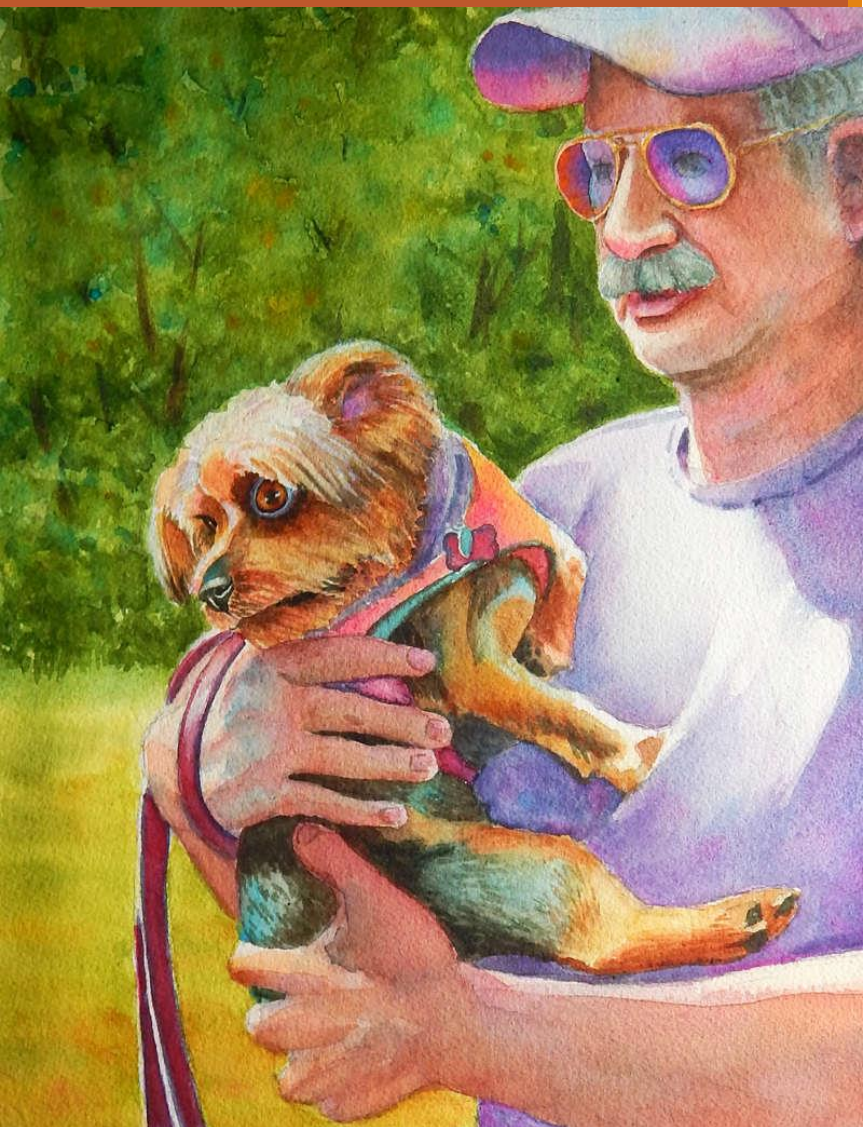
Institutions were categorised by their management type (government, religious and non-religious management).



*61.8% of those abused in institutions managed by a religious organisation were managed by the Catholic Church

(This represented 36.2% of all survivors).

Understanding Perpetrator Behaviour



Adult perpetrators use a wide range of tactics and strategies, including:

- Grooming, coercion and entrapment to enable, facilitate and conceal the sexual abuse of a child.

Examples:

- *Teacher with pets in class,*
- *Priest taking pairs of boys camping and hunting,*
- *Owner of a sports shop using sports car and toy cars to groom,*
- *Minister using power as agent of god.*

Not all child sexual abuse involves grooming.

Perpetrators may use physical force or violence as a tactic to overcome a child's resistance to sexual abuse. This may include coercion, threats and punishment. This instils fear to enable or facilitate child sexual abuse and silence the victim.

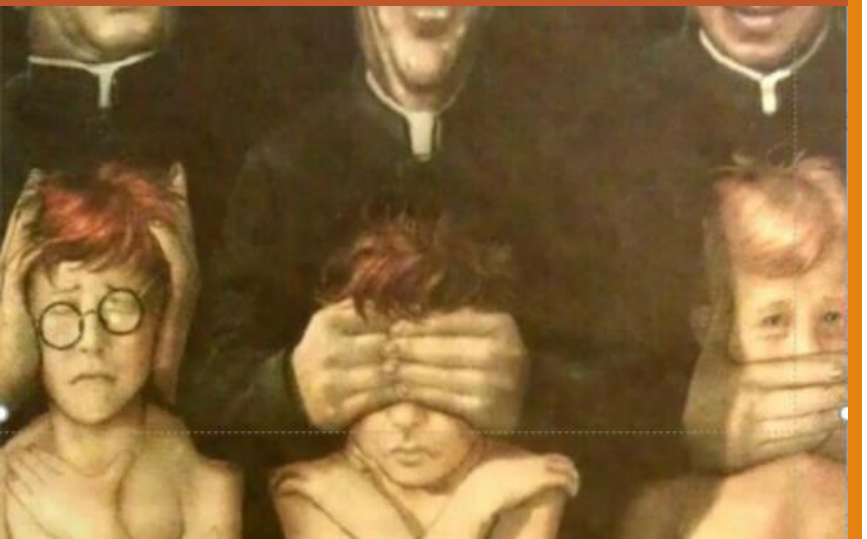
Child sexual abuse is often accompanied by other forms of maltreatment, including physical abuse, emotional abuse, and neglect. Survivors often told us that they experienced **multiple forms** of abuse at the same time.

Grooming

Grooming behaviour:

- Is not just aimed at children but other people in the child's life, including their family and institutions.
- Often occurred over an extended period of time to normalise the extra attention the perpetrator was showing the child and to gain their trust.
- Can take place in person and online, and is often difficult to identify and define.
- Involves behaviours that are not necessarily explicitly sexual, directly abusive or criminal in themselves, and may only be recognised in hindsight.
- Is consistent with behaviours or activities in non-abusive relationships, and can even include desirable social behaviours, with the only difference being motivation.
- *Example: Manager reading child a book at bedtime.*

Common Features to Perpetrator Roles



A number of features were common across many of the roles. These features often facilitated or enabled the sexual abuse. They included:

DOMAIN	Characteristics
Opportunity	• Unsupervised, one-on-one access to a child, such as travelling alone with the child, • Opportunities to become close with a child and their family, & • Providing intimate care to a child or an expectation of a certain level of physical contact.
Power and influence	• Authority over a child, particularly in situations with significant control such as a residential setting, • Responsibility for young children, such as preschool carers, • Spiritual or moral authority over a child, • Prestige of the perpetrator, resulting in the perpetrator being afforded a higher level of trust and credibility, • The ability to influence or control aspects of a child's life, such as academic grades, and • Specialist expertise, as in the case of medical practitioners, that enabled perpetrators to disguise sexual abuse.

Understanding Why Child Abuse Occurs

Interaction of factors:

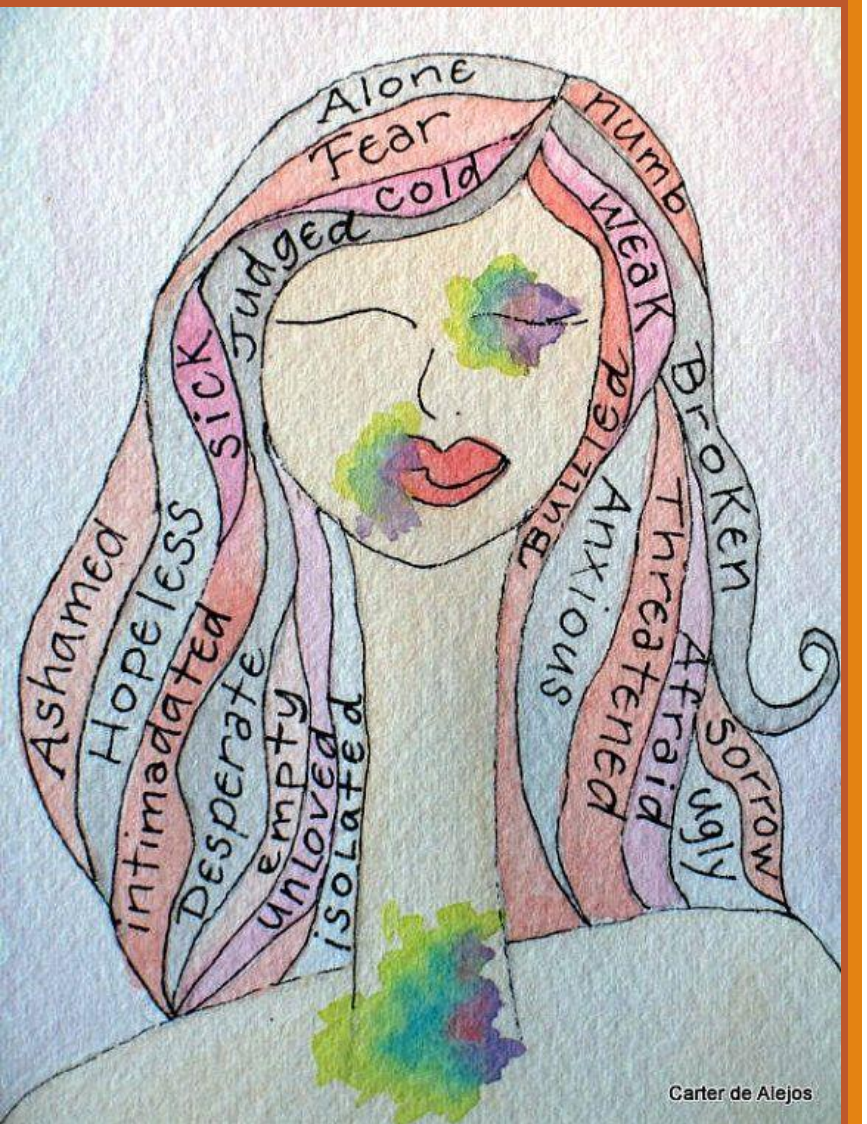
Adult perpetrator or child with harmful sexual behaviours	X	Institution	X	Vulnerability of victim	=	Risk of child sexual abuse

Research suggests four pre-conditions must be met before an adult will sexually abuse a child.

- Motivation to sexually abuse,
- Overcoming internal inhibitions the perpetrator may have about sexually abusing a child,
- Overcoming external barriers to access a child, and
- Overcoming the child's resistance.

These pre-conditions provide a useful framework for understanding and preventing child sexual abuse.

Impacts



'As a victim, I can tell you the memories, sense of guilt, shame and anger live with you every day. It destroys your faith in people, your will to achieve, to love, and one's ability to cope with normal everyday living.'

The impact of child sexual abuse is different for each victim.

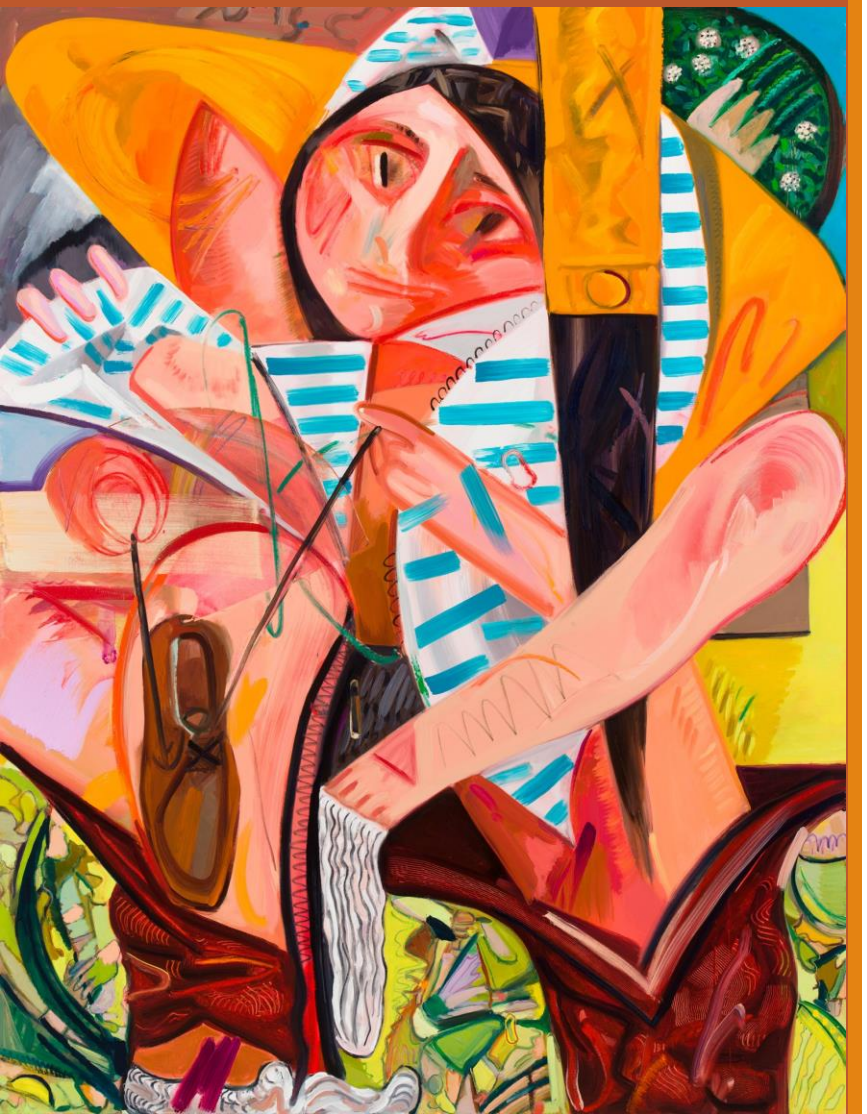
It can have profound and lasting impact across the lifespan.

As victims have new experiences or enter new stages of development over their life courses, the consequences of abuse may manifest in different ways in response to various triggers and events.

For some, vulnerability to sexual abuse and its adverse impacts was heightened by loss of connection to family, culture & country.

The impact of child sexual abuse in institutions can extend beyond survivors, to family members, friends, and whole communities.

Impact of Child Sexual Abuse



Child sexual abuse can affect many areas of a person's life:

- Mental health (95%),
  - Depression, anxiety and post-traumatic stress disorder,
  - Other symptoms of mental distress such as nightmares and sleeping difficulties,
  - Emotional issues including feelings of shame, guilt and low self-esteem,
  - Addictions, and
  - Criminal behaviour.
- Interpersonal relationships (67.6%) – including difficulties with trust, intimacy, confidence, parenting, and relationships,
- Physical health,
- Sexual identity, gender identity and sexual behaviour,
- Connection to culture,
- Spirituality and religious involvement

(loss of faith or trust in a religious institution),

- Interactions with society

(including distrust and fear of institutions and authority),

- Education, employment and economic security (55.7%), and
- Suicide.

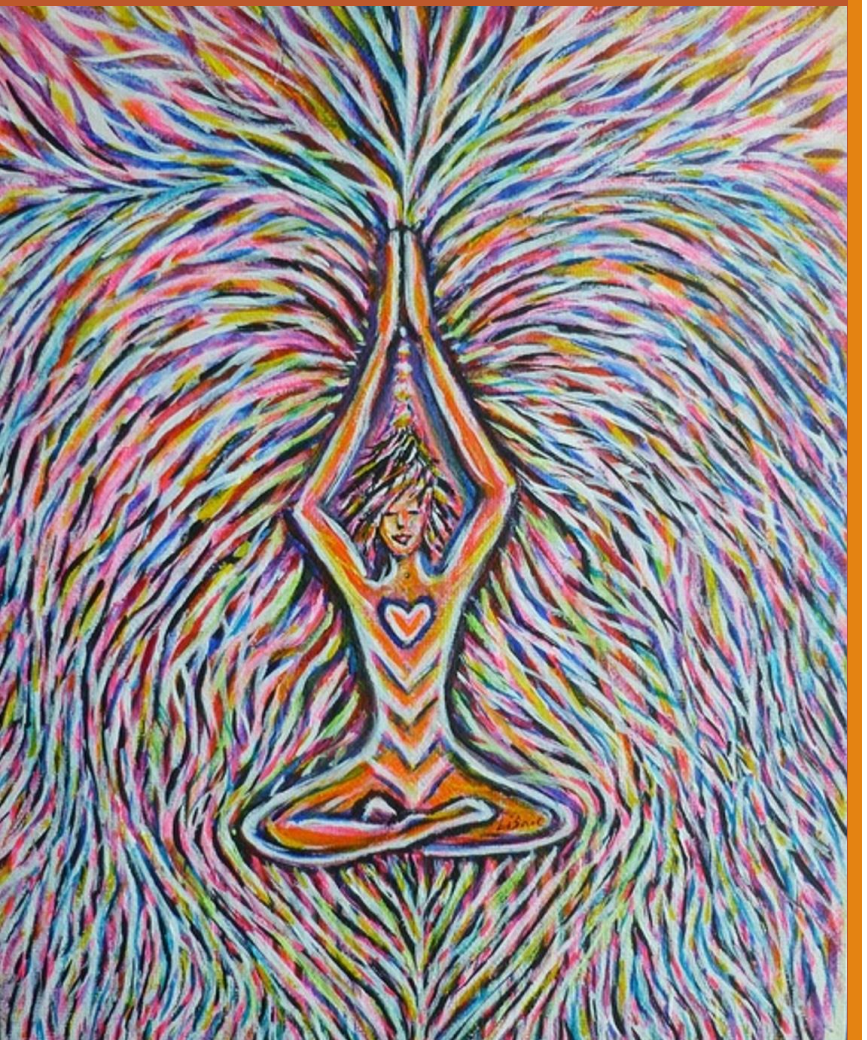
Protective Factors

Protective Factors may reduce vulnerability to sexual abuse and include:

- Supportive and trustworthy adults,
- Supportive peers,
- A child's adequate understanding of appropriate and inappropriate sexual behaviour, including sexual abuse, and personal safety,
- A child's ability to assert themselves verbally or physically to reject the abuse, and
- Strong community or cultural connections.

The culture and practices of institutions as well as community standards have pivotal roles in the prevention of child sexual abuse.

Sources of Strength & Resilience



The sources of strength and resilience identified include:

- Strong relationships and social support from families, peers and others,
- Therapeutic activities,
- Education, work and leisure activities,
- Spirituality,
- Cultural connection, and
- A variety of inner resources, such as optimism and hope.

Institutional responses also have the potential to either significantly compound or help alleviate the impacts of the abuse.

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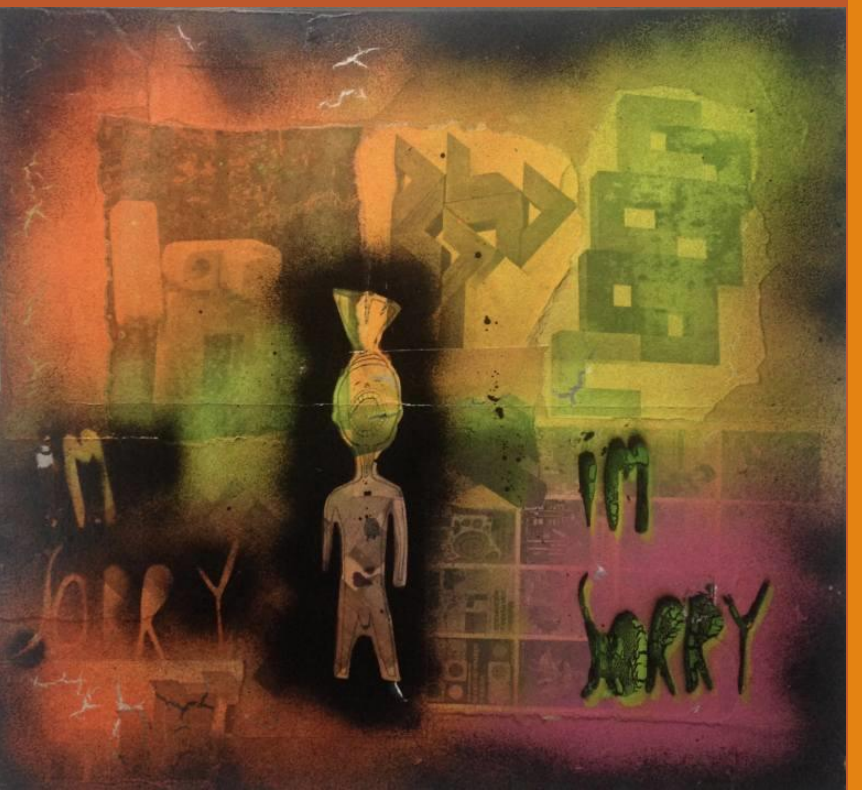
The Redress Scheme

The Redress Scheme



The Redress Scheme is:

- A government program arising from the RC to support people abused while in the care of an institution.
- A form of government acknowledgement of past abuse.
- Commenced on 1/7/2018 and will run for 10 years.
- Designed so relevant organisations take responsibility.
- Other government sectors and organisations are being encouraged to 'opt in'.
- The Redress Scheme can provide three things:
  - Access to psychological counselling,
  - A direct personal response – such as an apology from the responsible institution for people who want it
  - A monetary payment.

Redress Scheme Payments

- Payments will be assessed on a individual basis considering the severity and impact of the abuse.
- The maximum payment will be $150,000.
- Redress is not compensation, it is about acknowledging the harm caused, and supporting people who have experienced child sexual abuse in an institution to move forward positively.
- The Redress Scheme is an alternative to getting compensation through the courts. People can do one or the other, but not both.

Who can apply?

Access to the Redress Scheme depends on:

- The type of abuse experienced:
  - Must include sexual abuse,
  - An institution must be responsible for the abuse. The Scheme doesn't cover non-institutional abuse, such as by a family member.
- Where and when it happened:
  - The abuse must have happened when the person was under 18 years of age.
  - It must have happened before 1 July 2018, when the Scheme starts (subject to the passage of legislation).
  - The institution or organisation responsible for the abuse must have joined the Redress Scheme.
- The person applying must be an Australian.

Support & Further Information

- **1800 Respect - Call 1800 737 732 or visit www.1800respect.org.au**

  24/7 telephone and online crisis support, information and immediate referral to specialist counselling for anyone in Australia who has experienced or been impacted by sexual assault, or domestic or family violence.

- **Lifeline - Call 13 11 14 or visit www.lifeline.org.au**

  24 hour crisis support and suicide prevention

- There are also a range of others services available nationally which can be found with futher information about the scheme at the following link: www.dss.gov.au/redress or the National Redress Information Line on 1800 146 713.

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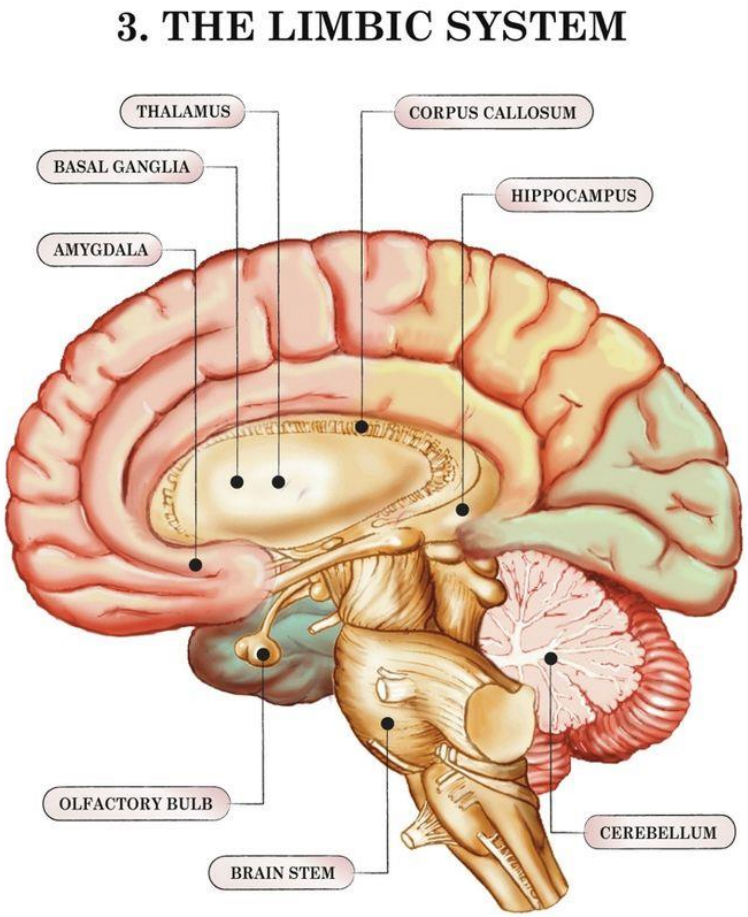
Neurobiology of Trauma

The Brain & Trauma



Spinal Chord – Highway for motor and sensory signals between brain and body.

Brain stem - Oldest part of brain. 300 million years old. Controls breathing, heart rate, etc. Home of flight, fight and freeze response. Creates a reactive state and works with the limbic system.

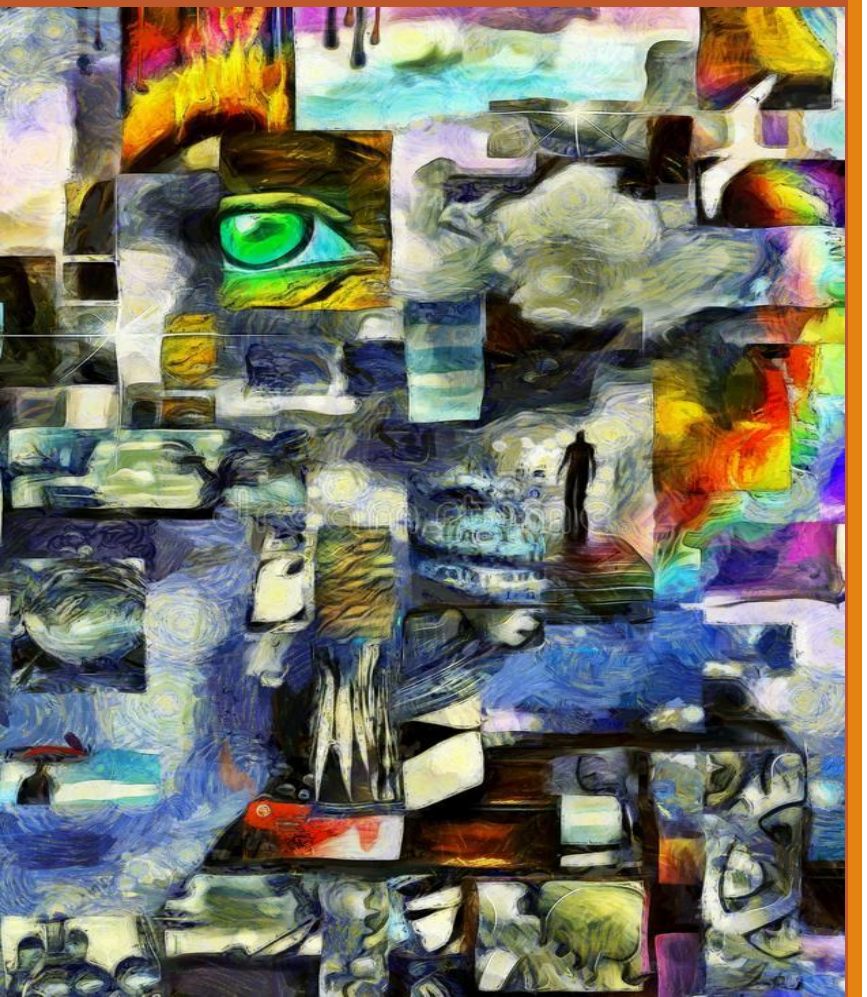
Limbic System - 200 million year old region. Works with brain stem and body to create emotion. Also motivates and drives our behaviours. It appraises the meaning of events. Memory is divided up and connected through the hippocampus and amygdala region. Also mediates attachment throughout the lifespan.

Cortex - Processes information from the senses to map outside world. Prefrontal cortex integrates: cortex, limbic area, brain stem, body and social world. When not integrated, thoughts become fractured and 'dis-integrated'.

Studies show the best predictor of wellbeing is how well your **connectome** is interconnected. **Integration** is likely the source of well-being in our relationship with others and nature.

Mindfulness integrates the whole system.

Neurobiology of Traumatic Memory



Post-trauma Amygdala Based Fear Network

When we experience fear, the amygdala fires through branches to other areas of the brain. The brain stem then secretes norepinephrine or noradrenaline and dopamine. This flood of neurotransmitters inhibits the ability of the frontal lobes.

When fear activates the amygdala, stress hormones are also released. These hormones interfere with the functioning of the hippocampus and sensory thalamus and alter how the brain processes information. We no longer encode experience the same way.

When the frontal lobe and hippocampus function normally, we encode and experience in context and sequence which is a normal function of memory. (e.g., getting married….)

When the brain is subjected to stress hormones, however, we have trouble remembering a traumatic event because the frontal lobes, hippocampus and thalamus are inhibited. Memory becomes jumbled. We only remember sensory fragments of flashbacks or nightmares. These are intrusive post-traumatic experiences.

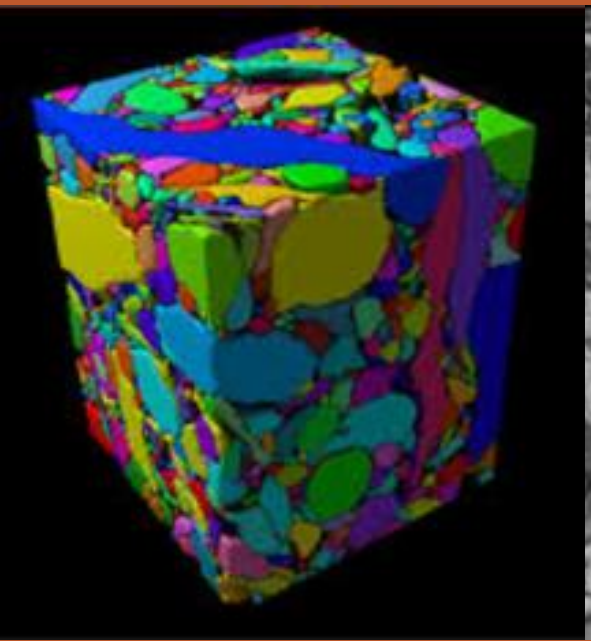
This knowledge influences how we interview clients. Clients who have been traumatised might not be able to recall events normally as their memory is fragmented. They can recall sensory fragments but might not be able to recall context and sequence.

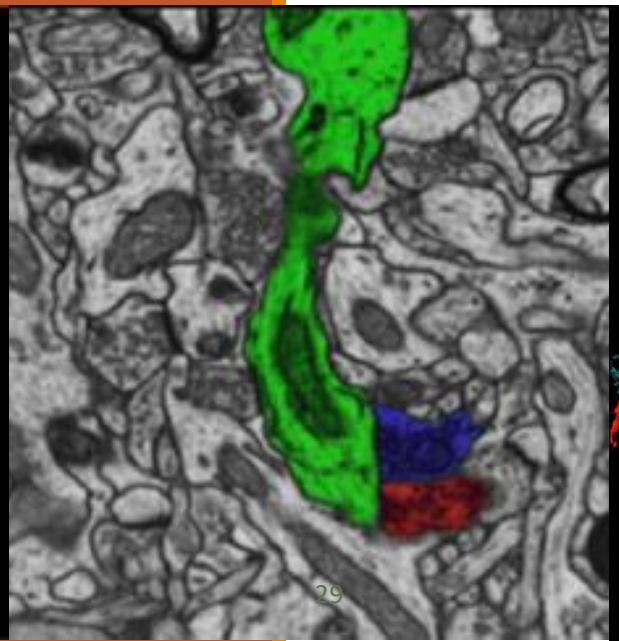
Example: Smell of oil on floor, vision of milk crate….

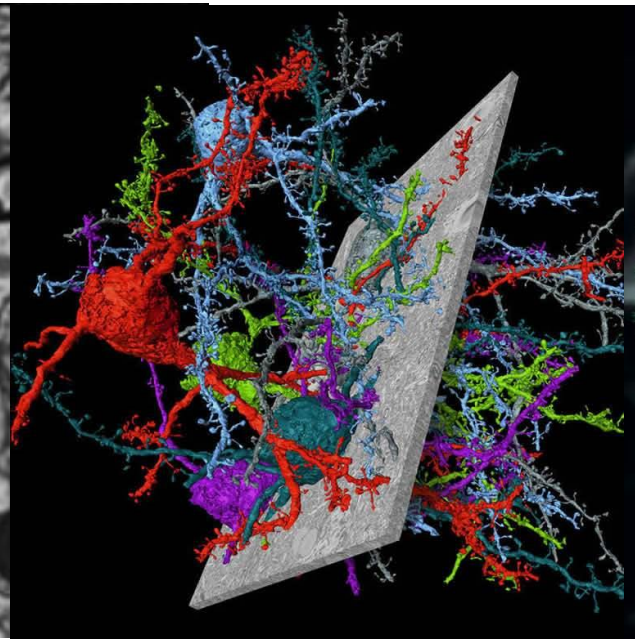
What is a Connectome?

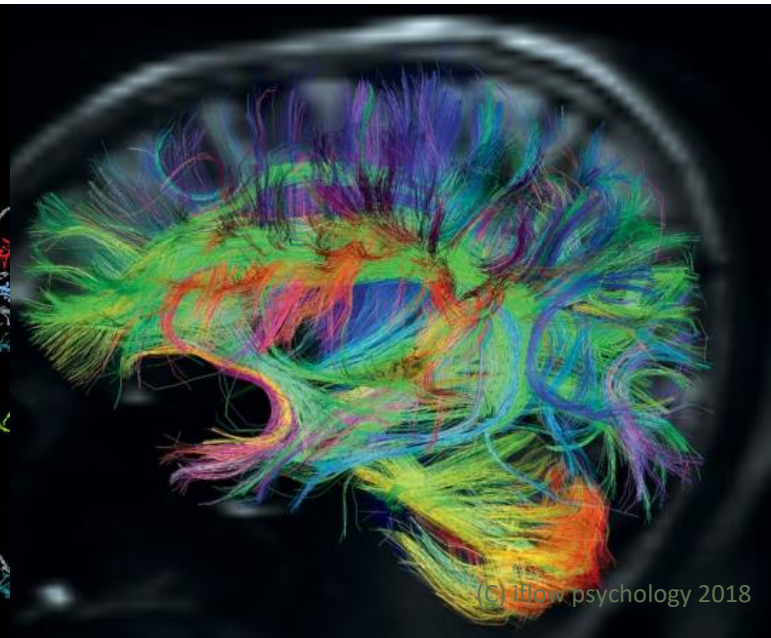
A connectome is a comprehensive map of neural connections in the brain, and may be thought of as its ‘wiring diagram’. More broadly, a connectome would include the mapping of all neural connections within an organism’s nervous system.

Pathways through cerebral matter can be charted by histological dissection and staining, degeneration methods and by axonal tracing.

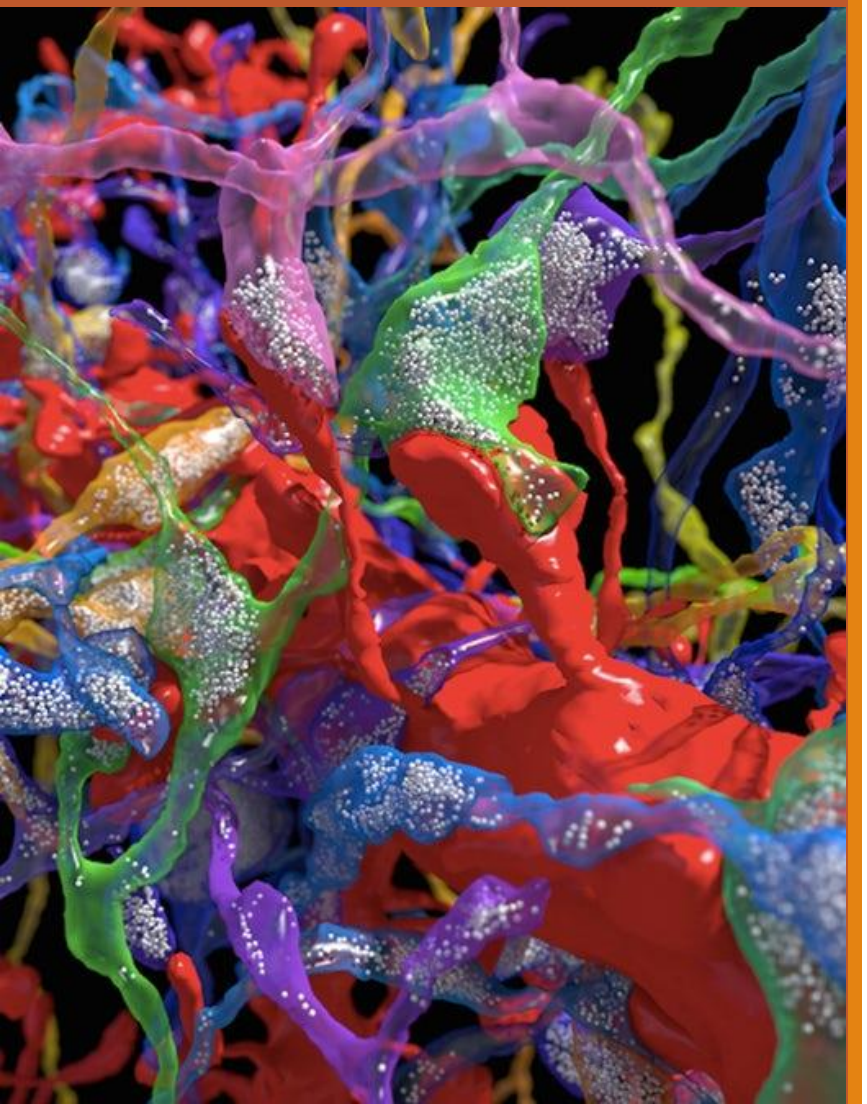








Connectomes and Trauma



The human brain is comprised of 100 billion neurons and ten thousand times as many connections.

As we develop, our brain changes. Changes include neuronal branches and synapses being created and lost. Synapses can also grow larger and smaller. These changes are programmed by genes but are also influenced by electrical and chemical signals or neural activity. Neural activity can cause connections to change.

Evidence indicates neural activity encodes our thoughts, feelings, perceptions and mental experiences. It is hypothesised, that our memories and identity are coded in the space between our neurons.

Together these facts suggest our experiences can change our connectome. **This is where nature meets nurture**. Just the act of thinking can change your connectome.

Metaphor - Neural activity is constantly changing like a the water in a stream. The connectome is like the bed of the stream. The bed determines the flow of water. Over time, however, the water changes the bed of the stream. So the water and the stream bed influence each other. This is thought to the same for the stream of consciousness interacting with our nervous system or brain.

So what does this mean?

Traumatic experiences will change our connectome, particularly where it is salient, repetitive and chronic.

Likewise, a corrective emotional experience, like positive experiences and therapy, will also influence the connectome particularly where it is repeated over time.

Our experiences, both positive and negative influence the development and functions of our brain and the way we experience the world.

This has implications for victims as well as support workers.

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Supporting Clients

Guidelines

Best practice principles to establish a trauma-centred framework for services supporting adults surviving child abuse include:

1. Providing a safe place for the client,

2. Ensuring client empowerment and collaboration,

3. Communicating and sustaining hope and respect,

4. Supporting disclosure, where appropriate, without overwhelming the client,

5. Viewing symptoms as functional adaptations, and

6. Being familiar with **trauma informed practice** (TIP).

*Adapted from the Adults Surviving Child Abuse (ASCA) Guidelines (Kezelman & Stavropoulos, 2012) and recommended by The Australian Psychological Society).

Trauma-informed Practice (TIP)

WHAT IS TIP?

TIP

TIP:

- Is a strengths-based framework, emphasising strength building and skill acquisition, rather than symptom management.

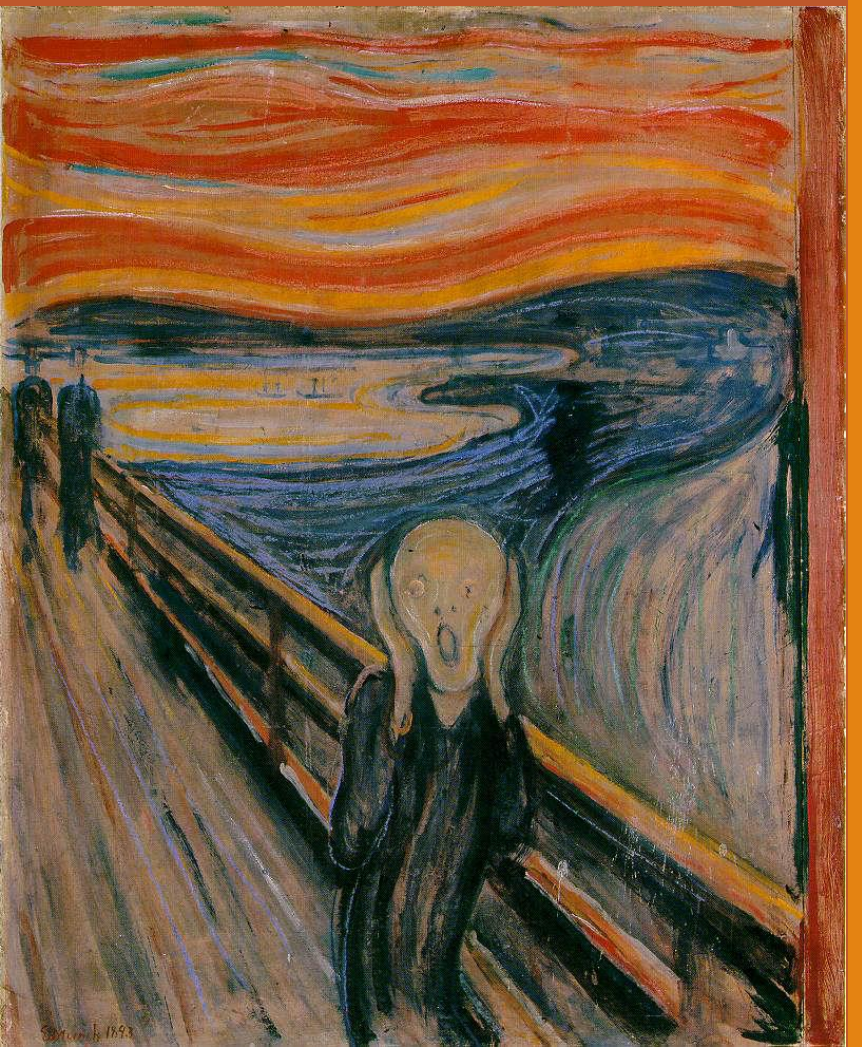
- Understands:
  - The dynamics of traumatic stress,
  - Survivors in the context of their lives, and
  - The role of coping strategies.

TIP

TIP is founded on five core principles:

- **Safety** from harm and re-traumatisation. Do no harm. Client behaviours are seen as normal reactions to an abnormal situation (functional adaptation). No victim-blaming.
- **Trustworthiness** - Meaningful sharing of power and decision-making. Transparency, clarity and consistency in operations and decisions to maintain trust.
- **Choice** - The aim is to promote an individual approach with active participation in decision making or choice. Offering even small choices makes a real difference.
- **Collaboration** - Recognition that healing happens in relationships and the meaningful sharing of power in partnerships.
- **Empowerment** (as well as respect for diversity) - An individual's strengths are recognised, validated and built upon. The support provided embraces hope and optimism about recovery.
- (Positive Asset Search)

Complex PTSD



PTSD is the most common clinical presentation of sexual abuse.

Abuse in institutional settings, however, is often insidious, chronic and recurrent. Such abuse may involve grooming, secrecy, shame and embarrassment more than shock, terror or pain. Survivors' responses may be quite different from the arousal, intrusion and avoidance symptoms characteristic of PTSD.

Trauma associated with child sexual abuse can differ from classical PTSD due to betrayal of trust & associated interpersonal difficulties.

PTSD may be one of multiple manifestations (such as persistent depressive disorder, personality disorder, or substance abuse) which relate to underlying complex trauma.

People with underlying complex trauma can present with multiple diagnoses, a history of confused diagnoses, or shifting presentations, each of which cannot be understood outside of the traumatic context.

Institutions can inadvertently re-traumatise survivors of abuse and reinforce non-help seeking behaviour.

Even Diagnosis can damage self-concept, if not informed by evidence-based treatment and trauma-focused practice.

Example: Rape victim – Ongoing trauma, 'I do not want to be broken.'

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Effects & Impacts on Workers

What is Vicarious Trauma?

One of the challenges for staff working with clients who have been abused is the need to be empathic, or emotionally present and understanding. This experience can have a personal impact on us.

There is evidence that individuals with high empathy hold positive worldviews. In individuals exposed to trauma victims, however, high empathy was related to a less positive world view supporting the concept of emotional contagion.

The signs and symptoms of vicarious trauma parallel those of direct trauma, although they tend to be less intense.

Signs of Vicarious Trauma

Domain	Examples
Emotional	• Sadness and mood swings • Anxiety and depression • Change in tolerance and irritability • Labile mood • Agitation and anger • Changed sense of humour • Feeling less safe in the world • Numbing
Behavioural	• Isolation and avoidance of people or duties • Poor home/work boundaries • Staying at work longer • Increased substance use • Engaging in risky behaviours • Sleep disturbance • Changed eating habits or changes in weight
Physical/physiological	• Headaches and somatic complaints • Skin conditions • Gastrointestinal complaints • Shaking and tics • Anxiety • Sweating, increased hear rate and blood pressure
Cognitive	• Negativity and cynicism • Becoming judgmental • Thinking about clients' traumas when at home • Difficulty thinking clearly, concentrating, and remembering things • Difficulty making day-to-day decisions
Sense of self	• Changed relationship with meaning and hope • Lack of sense of purpose • Decreased sense of agency • Reduced sense of connection to others • Challenged to maintain a sense of self as viable, worth loving, deserving

Organisational Responsibility

'When self-care is prescribed as the antidote for burnout, it puts the burden of working in unjust contexts onto the backs of us as individual workers'. (Vikki Reynolds)

- Self-care is not only about individual workers, it is also about organisations and communities.

- *Metaphor: Sharing buckets.*

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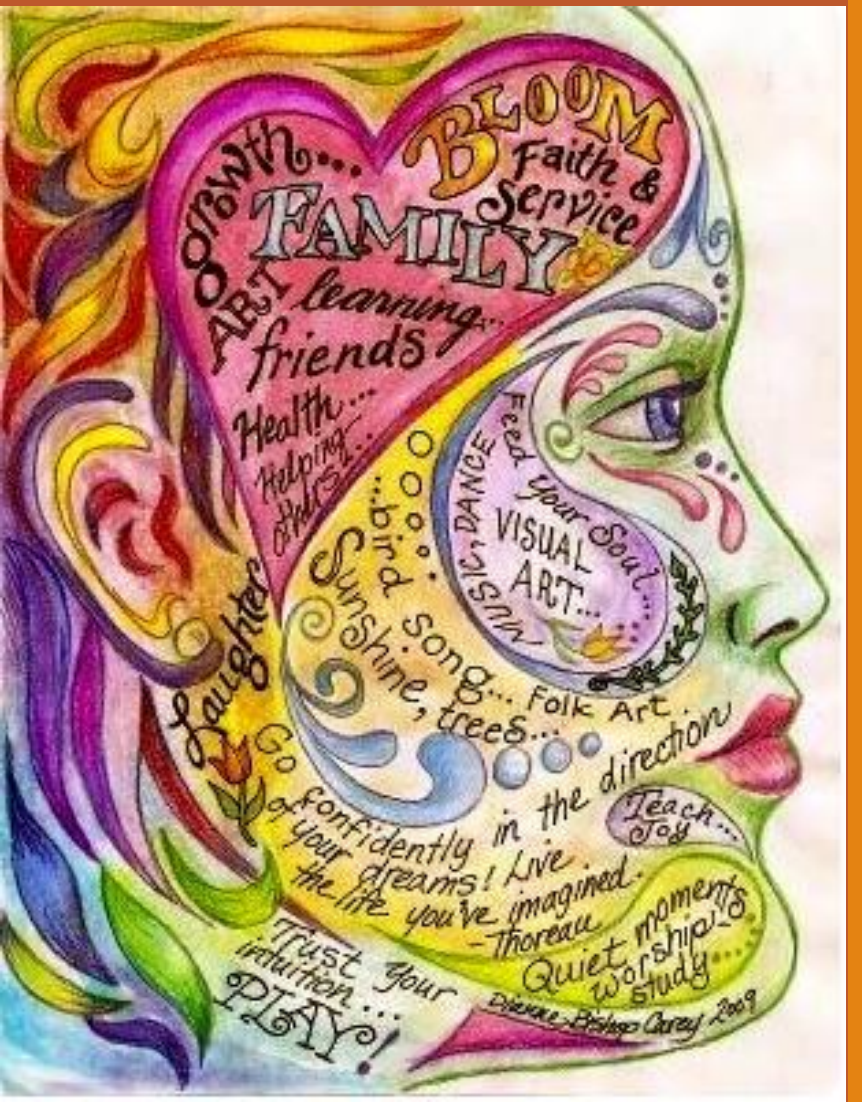
Care Strategies

Care Strategies



Establish and maintain a professional support structure including:

- Individual coaching,
- Individual clinical consultation,
- Group/peer supports to share experiences and reconnect,
- Planned leave,
- Regular breaks,
- A balanced and reasonable workload,
- A culture of care,
- Humour,
- Ongoing education and training,
- Life balance and rest including socialising with friends and family, being involved in creative activities, and being physically active to preserve a sense of personal identity and reality,
- Activities to increase personal tolerance, such as journaling, counselling, meditation, and emotional support from significant others,
- Connection with others and community participation,
- Physical activity,
- Relaxation,
- Mindfulness and flow, and
- Giving and Gratitude.

Meaning

The effects of vicarious trauma are often related to a loss of a sense of meaning, and can influence ways of thinking about self, others and the world. Without a sense of meaning, mental health professionals who work in the trauma field may feel cynical, withdrawn, emotionally numb, hopeless, and outraged, and experience sorrow, confusion and despair.

Intentionally engaging in practices that re-connect you to your professional and personal ethics, beliefs and values is an important part of feeling sustained in the work. This could be through supervision conversations which make space for questions of ethics, purpose and intentions; connecting with colleagues who share similar hopes and values; and engaging in community activism around issues of significance.

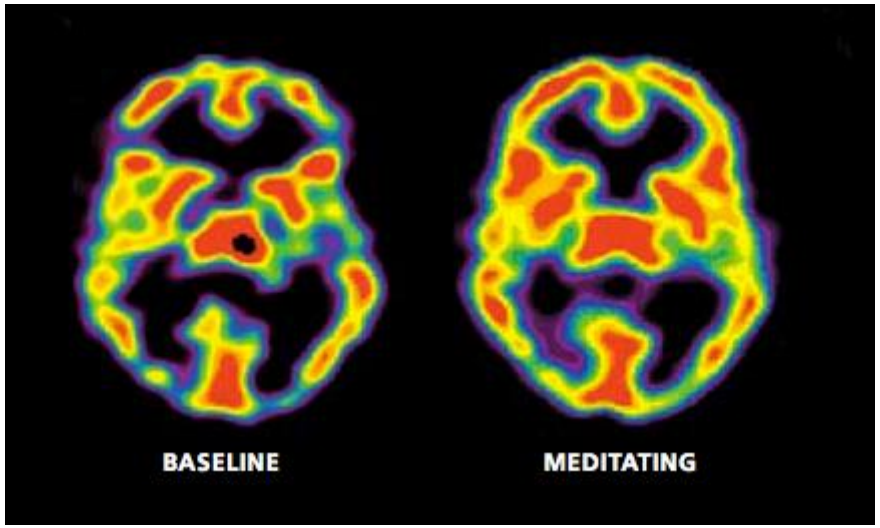
Seek out regular peer and individual professional supervision.

Mindfulness

Mindfulness is the psychological process of bringing one's attention to experiences occurring in the present moment.

In mindfulness we:

- Avoid dwelling on the past or anticipating the future.
- Live in the moment with full awareness of current experience
- Focus on sounds, sensations, thoughts and feelings happing in the present moment without judging them,

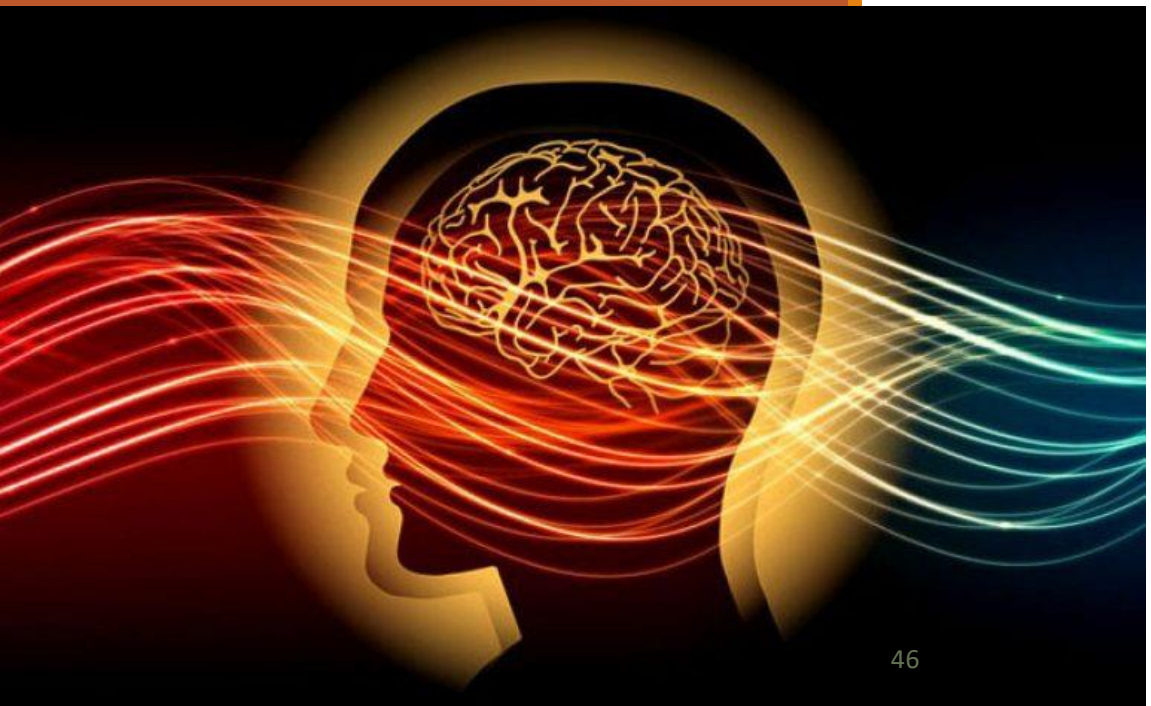


Integrated flow may be at the heart of how mindful awareness creates well-being.

Flow

Flow, also known colloquially as being in **the zone**, is the mental state of operation in which a person performing an activity is fully immersed in a feeling of energized focus, full involvement, and enjoyment in the process of the activity. In essence, flow is characterized by complete absorption in what one does, and a resulting loss in one's sense of space and time.

Look at video's on Flow at www.iflowpsychology.com.au



Gratitude as a form of Mindfulness

https://youtu.be/gXDMoiEkyuQ?t=1m

CRISIS SUPPORT

If this presentation has raised any concerns or issues for you please contact the following numbers:

- Lifeline **131 114**
- Ambulance **000** or
- Go to your local hospital emergency department.

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Finish

THANK YOU FOR PARTICIPATING!

Archive

- Females reported being younger when they were first sexually abused than males (9.7 years compared with 10.8 years, respectively),
- 67.3% provided information on the age of the perpetrator at the time of the sexual abuse with 83.8% reporting they had been abused by an adult.
- The most commonly reported roles of those that perpetrated abuse were people in religious ministry and teachers.