

**ROYAL COMMISSION INTO INSTITUTIONAL
RESPONSES TO CHILD SEXUAL ABUSE**

**Public Hearing - Case Study 28
(Day C81)**

Ballarat Magistrates' Court,
100 Grenville Street, South Ballarat
Victoria

On Monday, 25 May at 10.00am

Before
The Presiding Member: Justice Peter McClellan AM

Commissioner: Justice Jennifer Ann Coate
Mr Andrew Murray

Counsel Assisting: Ms Gail Furness SC

1 THE CHAIR: Yes, Ms Furness.

2

3 MS FURNESS: Your Honour, can I indicate first, that there
4 has been an issue with the air conditioning.

5

6 THE CHAIR: We've noticed, Ms Furness.

7

8 MS FURNESS: I suspect that many people have noticed.
9 Just to indicate that, I'm not sure whether it's going to
10 be fixed, but there is an issue.

11

12 Secondly, can I indicate that Dr Quadrio is the
13 witness for today, and indeed the only witness today, and
14 Father McInerney will be giving evidence tomorrow. It may
15 well be that today is shorter than usual.

16

17 So, perhaps if the witness could be sworn, Your Honour

18

19 <CAROLYN QUADRIO, sworn: [10.20am]

20

21 <EXAMINATION BY MS FURNESS:

22

23 MS FURNESS: Q. Would you tell the Royal Commission your
24 full name and occupation?

25

26 A. Carolyn Quadrio, and I am a Conjoint Associate
27 Professor with the School of Psychiatry with the University
28 of New South Wales and a consultant child and family and
29 forensic psychiatrist.

29

30 Q. Thank you, doctor. Would you tell the Royal
31 Commission your qualifications?

32

33 A. Yes, MBBS, which is a medical qualification; DPM,
34 which is psychological medicine, a PhD and Fellow of the
35 Royal Australian and New Zealand College of Psychiatrists
36 in the faculty of psychotherapy, forensic psychiatry and
37 child and adolescent forensic psychiatry.

37

38 Q. What did you do your doctorate of philosophy in,
39 doctor?

40

41 A. In gender issues and the influence of gender on mental
42 health, and particularly women and mental health.

42

43 Q. Since 1985 you've worked as a teaching supervisor in
44 major teaching hospitals in Sydney?

45

46 A. That's right.

46

47 Q. What was your role as teaching supervisor?

1 A. I've been supervising teams and also individual
2 trainees in the management of trauma particularly, sexual
3 trauma with children and with adults and a range of
4 psychiatric disturbances as well.

5

6 Q. In relation to the trauma of sexual abuse, is your
7 work both in institutional abuse and familial abuse?

8 A. Yes.

9

10 Q. Do you tend to work in one area more than the other?

11 A. I've seen a lot of both. I think in sheer numbers,
12 probably I've seen more intrafamilial abuse, but I've also
13 seen quite a few of institutional abuse as well.

14

15 Q. Where has your clinical research been primarily
16 directed?

17 A. I primarily looked at sexual abuse of patients in
18 psychiatric treatment and the abuse of patients in medical,
19 clinical treatment relationships generally, and I've also
20 looked at the influence of gender on mental health, and
21 family therapy and psychotherapy.

22

23 Q. You refer to a study of more than 200 men and women
24 who were sexually abused in childhood by members of the
25 clergy or by teachers or other caretakers; can you tell us
26 about that study?

27 A. That's not one study. I first became involved in
28 assessing institutional abuse in the 1980s, when the
29 Christian Brothers case in WA first became a matter of the
30 courts and there were 250 plaintiffs in that case. I
31 didn't assess 250, they gave me 32 to assess, which were
32 going to be a sample, so I assessed 32 men in the late
33 1980s in that case.

34

35 After that, I haven't had a big group like that again,
36 but I've had --

37

38 Q. Before you go on to another group; what were your
39 findings?

40 A. The Christian Brothers, they were men who mostly come
41 out from Britain, some from Malta, but mostly from Britain.
42 They were called child migrants, although they were not
43 really migrants, some of them weren't here voluntarily;
44 some of them had just been told they were coming, so
45 migrants is a fairly generous word.

46

47 A lot of them had been in orphanages in England.

1 Often they were children of single mothers who hadn't been
2 able to care for them because there was very little social
3 security for single mothers in the 1940s. Some of them had
4 been left by their mothers in the institutions with the
5 idea that they would come back and get the children later,
6 but when they came back, the children weren't there
7 anymore. So, the whole migration process in itself was
8 quite an abusive thing really, because it was an
9 understanding between the governments of Australia and
10 Britain really about bringing these children over.

11
12 So, they were very vulnerable children and they came
13 to WA and they were sent to - there was one particular
14 place, Bindoon, which was quite a way out of town so it was
15 quite isolated. It was systematic abuse in that
16 institution, so there was a lot of abuse; there was
17 physical abuse, there was sadistic physical abuse, there
18 was very severe privation, very little education, the boys
19 were working, doing hard manual labour a lot of the time,
20 and there was a lot of sexual abuse as well, so it was a
21 very brutal environment .

22
23 There were three institutions, but Bindoon had the
24 largest number of boys in it. There was also Clontarf and
25 Tardun, so that's where the 32 came from. So, those men
26 were extremely damaged psychologically because there had
27 been just so much trauma; there was much more than the
28 sexual abuse. There was the loss of country and connection
29 with their homeland and whatever family they might have
30 had. There was a lot of physical abuse, so that was part
31 of it as well, a lot of verbal abuse; they were denigrated
32 by the Brothers all the time, you know "you dirty Pommie
33 bastards", and "bastards" being used particularly because a
34 lot of them were the children of single mothers.

35
36 They didn't get much education and then there was the
37 sexual abuse as well. And, if they showed any signs of
38 distress, they were punished, so it was a really abusive
39 environment and they were very, very damaged. So, they led
40 very difficult lives. There was a lot of depression,
41 unemployment, alcoholism, very few of them were able to
42 make relationships outside of the - when they left the
43 institution they struggled to make relationships. If they
44 did have children, they struggled to relate to their
45 children; they were always - they seemed to live in fear
46 and dread that they might harm their own children, so that
47 caused them tremendous distress. There was suicidality.

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A lot of them made disclosures, so it's not that it was kept secret; many of them made disclosures when they got out of the institution and they were discredited. Everywhere they turned they were told they were lying and it wasn't possible that this could - that men of the church could do this, and so, after a while they stopped complaining because they could see it was futile.

Q. And the purpose of your assessment was to provide a report for the litigation?

A. Yes, there was litigation, and so I assessed them and submitted 32 reports to the court.

Q. You were going to go on to talk about another study.

A. I also saw - interesting from the point of view of looking at different kinds of abuse, I saw an interesting contrast, because it was a group of I think seven boys who were at a private school; quite the opposite --

Q. Sorry, seven or 70?

A. Seven from a private school, and so they were boys that came from intact families, mostly they had good families, they were often from rural areas and had been sent to the boarding school because they were not close to a high school. So, these were quite the opposite, with good intact families and going to a good school, and they also were extremely damaged by their experiences, so it was useful to compare that the children will be just as badly damaged even when everything else in their life seems to be relatively sound, and even so, the sexual abuse is quite damaging. In that case there was very little in the way of physical abuse; in fact, there was no physical abuse, so it was strictly sexual abuse.

But it was a particular offender who groomed the boys, and the grooming was very prolonged and effective, and that has its own consequences in that it's a very psychologically abusive process to be groomed; quite different from the systematic abuse of the Western Australian experience.

Q. And that, again, was for the purpose of litigation?

A. Yes.

Q. Are there any other studies that you've been involved in?

1 A. Not groups, no. The other ones have been two or three
2 here and there.

3

4 Q. And again, for the purposes of litigation?

5 A. Yes.

6

7 Q. You've presented in a number of workshops and other
8 forum in relation to clergy abuse. Perhaps you could tell
9 us about your more recent presentations.

10 A. Yes. In 2008 I helped convene a conference in Sydney
11 on sexual abuse in religious organisations and we invited
12 people from all the major faiths to participate. That was
13 interesting, in that, there were some faiths that said, "We
14 don't have a problem, it doesn't happen in our church".
15 But the major churches, the Catholic Church, the
16 Anglican Church, they participated.

17

18 We had a lot of survivors who came, and help
19 organisations as well, and we gathered speakers from Europe
20 and North America, so that was a very interesting
21 conference. We tried to roll that into a research program
22 afterwards but we couldn't get any funding, nobody was
23 interested in funding it in 2008. We approached the
24 churches for funding and they weren't interested in funding
25 it either so we didn't get any further with it.

26

27 Q. Did any new learnings come out of that conference?

28 A. I think the new learning was to see that the issue is
29 global and that it's very similar in one country and
30 another and it's very similar in one faith group and
31 another, much as some of the faith groups at the time said
32 "we don't have that problem", all of those faith groups
33 have since had problems that have been widely reported in
34 the media. I think what we learnt is what is well-known,
35 that it's a global problem and it occurs in every faith
36 group.

37

38 Q. What were the parameters of the research project that
39 you wished to come from that conference?

40 A. We wanted to look at what were the organisational
41 issues. We had an ethicist and a philosopher looking at
42 how organisations allow abuse to continue and flourish, and
43 that was what we wanted too. We weren't going to take an
44 individual psychological study, it was going to be about
45 organisational issues.

46

47 Q. Has any work been done in that area since 2008 to your

1 knowledge?

2 A. Not by my group. I think there has been work though
3 done in other organisations.
4

5 Q. In 2010 you gave the keynote address to the Survivors
6 of Clergy Abuse Conference on Difficulties in Disclosure.

7 A. On difficulties?
8

9 Q. In disclosure?

10 A. Oh, disclosure, yes, yes.
11

12 Q. What was that topic, difficulties in disclosure, that
13 you spoke of?

14 A. The difficulties in disclosure is a huge issue with
15 children who are abused - well, with adults as well;
16 children usually don't make disclosures at the time of the
17 abuse, so that really allows it to continue because they
18 usually don't make disclosures and the trouble is, when
19 they do make disclosures they're often not believed, so
20 disclosure is a really critical element. And not being
21 believed itself is an extremely damaging experience so that
22 compounds the trauma that they've already been subjected
23 to.
24

25 A lot of the clinical work that I've done has been
26 with adults who are now disclosing what happened when they
27 were children, and they've often experienced years
28 and years of not having talked about it, and part of their
29 life is kind of cut off, part of their experience is cut
30 off. Some of them are married and never told their spouse
31 what happened. So there have been many years of living
32 that kind of secrecy.
33

34 When they do disclose, they're still, even today, even
35 at this stage of our development, there's still often very
36 negative reactions to victims, so that it's a very
37 traumatic process, disclosing.
38

39 Then the disclosure itself is very traumatic. It's
40 like once something is spoken, somehow it hurts all over
41 again, so the whole disclosure process is really very
42 difficult.
43

44 Q. In 1998 you presented a paper at the annual conference
45 of the Faculty of Child and Adolescent Psychiatry for the
46 College of Psychiatrists on systematic sexual abuse of
47 children by clergy.

1 A. Yes.

2

3 Q. In 1998 what was known about that?

4 A. By 1998 it was fairly well-known. In Australia, for
5 example, the Christian Brothers case was widely known by
6 then, that was litigated around 1991 I think, and there had
7 been lots of other cases. Also, by 1998 in America there
8 was a huge case in Boston and so there'd been a huge amount
9 of media attention to the Boston case, so I think by then
10 it was getting to be very well-known that systematic sexual
11 abuse within religious organisations was a problem in the
12 world.

13

14 But still, I don't think victims were being very well
15 assisted in 1998. I think that was just the beginning,
16 maybe, of being able to assist victims, but it wasn't good
17 for victims at that stage.

18

19 Q. Prior to the Christian Brothers cases becoming known
20 in 1991, what was known in your area of work?

21 A. I'm afraid that was the dark ages for psychiatry.
22 There was very little attention - I think psychiatry was
23 just as much in the dark as the general community, assuming
24 that it didn't happen in religious organisations and so
25 forth. I mean, even abuse within the family wasn't very
26 well recognised, so I think psychiatry also in the 1980s
27 had to make a big shift to understand the extent of child
28 abuse. Even now; I think psychiatry hasn't really fully
29 taken on board the extent of child abuse and how damaging
30 it is and how prevalent it is.

31

32 Q. Did psychiatry come out of the dark ages, as it were,
33 following convictions of perpetrators of child sexual abuse
34 in the clergy?

35 A. I think it's been a very slow process. I think
36 changing community attitudes is extremely hard, it's been a
37 very slow process.

38

39 Q. But is convictions the main reason that there is a
40 change or is there something else that occurs?

41 A. Convictions, yes, and the publicity. I think the
42 survivor organisations have been very effective in becoming
43 heard and in lobbying; I think the survivor organisations
44 really have done a lot to lobby psychiatry to take their
45 difficulties seriously and understand the effect, and
46 there's been a lot of research that's accumulated too, so a
47 lot of good research work's been done over the last

1 20 years. There's a huge body of research now that's
2 available.

3
4 Q. When you say you don't think psychiatry is quite there
5 yet in relation to victims or survivors, what do you mean?

6 A. I think psychiatry is still rather pre-occupied with
7 the idea of diagnosis and medical treatment, whereas abuse
8 and trauma doesn't fit neatly into a diagnosis, it's
9 usually much more pervasive than a single diagnosis,
10 especially if the person was a child when the abuse
11 occurred, and so I think psychiatry has been rather focused
12 on diagnosis and medication as treatment. So, that
13 approach doesn't really help trauma survivors at all, they
14 need a much more holistic approach than that. And
15 medication can be helpful symptomatically, but there's no
16 medicine that will cure trauma.

17
18 Q. When you say a more holistic approach, what would that
19 involve?

20 A. Well, if a person's abused in childhood, it affects
21 every aspect of their development. So, there's no kind of
22 discrete area of their function that you can point to,
23 whereas most psychiatric diagnoses tend to focus on more
24 discrete areas of dysfunction; you know, like depression.
25 Well, people who have been abused are usually depressed,
26 but that's not all; it affects them in many ways. Children
27 will be affected in terms of their capacity to form
28 relationships, their ability to function at school, their
29 ability to progress in education, then their ability to
30 progress in employment. They're often anxious, depressed,
31 they often turn to alcohol or drugs as a way of kind of
32 medicating their distress, and so then substance abuse
33 becomes a problem.

34
35 So far as psychiatry is concerned, for a long time
36 they've been treated as substance abusers, rather than as
37 trauma survivors who are relying on substances to treat
38 their symptoms

39
40 THE CHAIR: Q. Professor, you use the word "abuse". Can
41 you let us know what you mean when you use the word
42 "abuse"?

43 A. You mean, child abuse?

44
45 Q. Yes.

46 A. Okay. Well, abuse of children can be physical,
47 psychological and sexual and often they all go together

1 depending upon the environment. So, the Christian Brothers
2 cases that I'm talking about, those children were subjected
3 to abuse in every possible sense of the word. Then I
4 mentioned that private school, that was a case where the
5 abuse was very much confined to the sexual relationship,
6 but that's psychologically abusive in itself, so it's
7 impossible to sexually abuse a child without
8 psychologically and spiritually abusing them as well.

9
10 Q. When you speak of sexual abuse then, what do you have
11 in mind?

12 A. Sexual abuse, I have in mind that there is actual
13 sexual contact.

14
15 Q. Meaning?

16 A. Well, it could be that there's some sort of physical
17 contact, and that ranges from touching to penetrative sex.

18
19 Q. And are we to understand that you say that the
20 symptoms that emerge, the outcome for the abused person,
21 may be the same but there may be different levels of abuse
22 as we would understand them?

23 A. Yes. And psychological abuse can be extremely
24 damaging without any physical component to it.

25
26 Q. When the law looks at sexual abuse, we generally tend
27 to differentiate between penetrative sexual abuse and
28 touching. Is that rational as far as psychiatry is
29 concerned?

30 A. No.

31
32 Q. Because the outcome can be the same?

33 A. Yes, and because there can be a lot of manipulation of
34 a child's mind by an offender, which is psychologically
35 damaging. And then for example, particularly with
36 religious organisations, there's the kind of enormous sense
37 of betrayal and loss of faith that's very damaging, and for
38 a young child to lose faith, that, you know, the world's a
39 bad place and good people are actually bad people and you
40 can't trust anyone, that's extraordinarily psychologically
41 damaging to a child.

42
43 MS FURNESS: Q. Where does grooming fit into your
44 definition?

45 A. The issue with grooming is that it's very
46 psychologically abusive because it's a manipulation of the
47 child's mind. In religious institutions, my experience is,

1 there hasn't been so much grooming in those contexts
2 because the children are already under the power and
3 control of the abuser, so in a sense they don't need to be
4 groomed.

5
6 But in the community, there's a lot of extensive
7 grooming that goes on, especially like teachers, family
8 friends who abused their friends' children, sports coaches
9 and that sort of - there's usually very extensive grooming
10 so that the child is gradually manipulated by the offender,
11 and sometimes made to feel they're special, that this is
12 very special attention. So there's a kind of a seduction
13 that goes on that really is a serious manipulation of the
14 child's mind.

15
16 Q. Is there any non-contact, including grooming, that you
17 would consider fits the definition of child sexual abuse?

18 A. Without touching?

19
20 Q. Yes.

21 A. Grooming is psychologically abusive, because it
22 distorts the child's reality.

23
24 Q. What have you learnt from your research and your
25 experience about the prevalence of sexual abuse of children
26 in institutional contexts, including religious or faith
27 based?

28 A. It's very common, I think. When children are in care
29 of any kind, they're subject to abuse by caretakers.

30
31 Q. They're subject to; what about, they have been abused?

32 A. Well, often you've got vulnerable children who are put
33 in institutions, so that's really a double jeopardy for the
34 child who may have come from an abusive home or an abusive
35 environment or a neglectful environment and is put into
36 institutional care and then is abused in institutional
37 care.

38
39 I think, as I just pointed out, the actual sexual
40 abuse itself is not necessarily what's most damage damaging
41 there. What's most damaging is for the child to feel
42 worthless, to feel betrayed, to feel they have no value, to
43 feel that they're just there to be used or abused and
44 that's extremely damaging to a child's psychological
45 development.

46
47 Q. Is there any work that you consider reliable that

1 tells you anything about numbers?

2 A. There's a huge amount of studies of numbers; there
3 have been numbers counted for a long time now. I think we
4 can reliably say that about 25 to 30 per cent of girl
5 children suffer some form of sexual abuse and something
6 like 5-15 per cent of boys, and they're fairly consistent
7 statistics, and in institutional care it's more than that;
8 that's in the general community.

9

10 Q. So that includes familial and stranger abuse, as it
11 were?

12 A. Yes.

13

14 Q. When you say it's larger in relation to institutional
15 care, are there any figures that you can refer to?

16 A. Again, it's around about 30 per cent of girls and
17 about 20 per cent of boys in institutional care.

18

19 Q. What are those figures based on, do you know?

20 A. There are lots and lots and lots of studies that have
21 been done now, and so there are figures from various
22 countries and various institutions. You have to really be
23 more precise and think about which particular country,
24 which particular institution, because in some institutions
25 it's like - in the Christian Brothers one there was
26 systematic abuse, so once it becomes a systematic issue the
27 numbers become very high. Otherwise, if it's not a
28 systematic issue, then it's much more random, but even in a
29 random situation, there's still a significant number of
30 children that are abused.

31

32 Q. In the research that you're aware of that has been
33 done using Australian children, what institutions have
34 caused the numbers to be greater?

35 A. In the Catholic Church the numbers are significant. I
36 think they have been the most studied.

37

38 Q. And do you think it's because they're the most studied
39 that the figures are more significant or do you think it's
40 something about the way the institution operates?

41 A. No, there have been a lot of studies done of abuse in
42 the Catholic Church in the United States, in a number of
43 countries, in Australia, in England, in Ireland, in
44 Austria, in the Netherlands, Mexico, so there are a lot of
45 studies that have been done and I think the consensus is
46 that there is a - although it happens in every faith group,
47 it seems to be more marked in the Catholic institutions.

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Q. Why is that?

A. I'm not sure myself. Some people have said that celibacy is a problem, other people say it's got nothing to do with celibacy. I think it's about the degree of control; it's a highly controlling organisation, with a strict hierarchy, and so, then you have a lot of control over people if you have a strictly hierarchical organisation, although most religious groups tend to be fairly hierarchical and rigid in their approach.

Q. Any other factors?

A. I think the issue of celibacy is important, not because - my opinion is, I don't think the celibacy drives child abuse, but I think that people who - they have men who for example have already got an orientation to be attracted exclusively to children as sex objects, they will feel more comfortable in the priesthood because it doesn't bother them - you know, the celibacy vow is not going to bother you if you're not interested in having sex with other adults, so obviously that will be a more comfortable environment. Then a lot of offenders seek situations where they can have access to children and seek situations where they have authority, so they have access, they have authority and they have the cover of a very respected profession.

Q. The emotional development of a boy or young man who goes into the priesthood at an early age, would that be a factor?

A. As I said, I don't think that celibacy is driving it; I think that what happens is that young men who are perhaps troubled in their sexual development and are not developing along the usual lines will obviously be attracted to an environment where they don't have to prove themselves as sexually adjusted in the conventional sense, so that's of great assistance. Then, those that have difficulty, an immature young man would be also attracted to an environment where there's a highly organised structure and he immediately gets some status from his profession.

Q. What about screening; what screening do you think should be put in place to screen those people out?

A. I don't think there's been any effective screening to date with the religious organisations.

Q. What would effective screening look like?

1 A. It's difficult to screen people as sex offenders,
2 because obviously it's not something that someone's going
3 to - it's not information that one's going to volunteer.
4

5 Q. It's not going to be a box that they tick on the
6 application form?

7 A. So people are not going to tick that box. A lot of
8 offenders will not show any abnormality psychologically or
9 psychiatrically.
10

11 Q. Is there any testing that's been looked at in the
12 research that you're aware of to move that area along so
13 that screening can be more effective; not just in
14 faith-based but in other institutions?

15 A. There's a lot of experimental designs to try and
16 detect people who are attracted to children sexually. A
17 particular researcher in America called Gene Abel who's
18 done a huge amount of work, and he's tried to develop a
19 screening for offenders, which is to have them look at
20 photographs and they measure eye movements and look at the
21 responses to pictures of adult males, adult females, female
22 children, male children and measure their eye responses.
23

24 There's also measuring penile responses which is more
25 complex, but the eye responses is reasonably reliable too.
26 But, you know, that's not foolproof. There's no - it's not
27 like a test you can do.
28

29 Q. What else can you do?

30 A. Well, general screening. So, anyone with a history,
31 and that was a problem in the church in the past, in that,
32 offenders were moved around to different areas and they
33 actually did have a past history. The same with - teachers
34 have been able to move interstate and so forth, so any past
35 history obviously is a problem.
36

37 Any psychological difficulties need to be looked at.
38 There's no particular psychological profile to look for.
39 Sociopathy or psychopathic traits are a worry, but there's
40 only a minority. Only a minority of offenders will be
41 clinically significant in that regard.
42

43 Within the Catholic Church, because of celibacy, you
44 can't look at measures of what we would call "normal sexual
45 adjustment", which you can in other institutions for
46 screening; look at the person's general sexual adjustment.
47 But a lot of that kind of screening depends on people

1 voluntarily talking about things like their thinking, their
2 fantasies, you know, what turns them on, you know and I
3 think it's very difficult to get a full disclosure from
4 people who are going into institutions to work.

5
6 THE CHAIR: Q. Professor, we've learnt and people often
7 have said to us that one of the problems for churches, but
8 particularly the Catholic Church, was the age at which
9 young boys, adolescent men, if you like, commenced
10 training, became part of an institution that would lead to
11 them ultimately becoming a priest.

12
13 Is there any reason to think that, if you delayed any
14 man from entering into training until he was into his 20s,
15 and perhaps had done some other tertiary education, that
16 that would be of benefit to the church insofar as
17 addressing this issue is concerned?

18 A. It would, in that, obviously an adolescent male is
19 much more easily inducted into any organisation that he
20 becomes a part of, any adolescent is more malleable. So
21 having a wider life experience and having already formed
22 values and ideas in a wider context would only be of
23 benefit.

24
25 Q. That's a general benefit, but in terms of identifying
26 those who may have psychosexual development issues that
27 lead to them offending if they were to become priests, is
28 there reason to think that delayed entry into a process of
29 training would be a good thing for the church?

30 A. For those who have a fundamental orientation towards
31 sexual interest in children, it probably isn't going to
32 make a difference, but there's no one single type of
33 offender. Some of them are exclusively sexually attracted
34 to children and I don't think age is going to make any
35 difference to that group.

36
37 There are others who we describe as situational
38 offenders who are very much responsive to the environment,
39 and that group will be certainly less likely to become
40 involved if they have a later age of induction, so they've
41 got more opportunities to develop themselves
42 psychosexually.

43
44 MS FURNESS: Q. You've said that there's a substantial
45 literature in this area. Can we firstly turn to the
46 short-term effects and then move to the long-term effects.

47 A. With children?

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Q. Yes.

A. First of all, about 20 to 40 per cent of children who have been abused won't show any symptoms at all, and that's because some of them are what we describe as resilient; children who somehow survive trauma and make a reasonably good development. But some of those apparently non-symptomatic children become symptomatic later on. That's called the sleeper effect; that they look fine at the time and then some years later something else triggers it.

So, the 20-40 per cent who are asymptomatic, it's really hard to know which ones of those are just going to be resilient their entire lives or which ones will in later life under certain circumstances be triggered to decompensate.

THE CHAIR: Q. Professor, when you speak of resilience; again, is the level of abuse or the period of time over which it occurs relevant to whether or not a child shows resilience?

A. Yes. It's relevant, but it's not the only factor. There are some human beings who are just remarkably resilient and we don't necessarily know why, they just seem to survive the most dreadful experiences. But, if you pile enough trauma onto any individual, there comes a point at which they can't take any more usually.

Q. And again, touching as opposed to penetrative sexual contact, does that show up as a factor that may mean that, for that individual, there's no consequence if they're merely touched?

A. Well, penetrative sex is the most traumatic form of abuse. So, when it's penetrative and when there's coercion or violence, that's extremely damaging. It's much harder for a child to survive that.

MS FURNESS: Q. What other short-term --

A. So that's the resilient group which includes some what we call sleeper effects. Otherwise, as I've said before, there's no particular syndrome of abuse. A child is disturbed and may show the disturbance in all kinds of ways. So, being sad, scared, unable to sleep, starting to bed wet, regressing in their behaviour, maybe being angry and aggressive, not functioning so well at school, maybe starting to refuse to go to school. The symptoms are those

1 that could be thought of as sort of general nervousness,
2 general unhappiness in a child.

3
4 Specific sexual acting out is one area that is of most
5 concern, because most of those other symptoms are symptoms
6 that can occur for a wide range of reasons and are
7 frequently misunderstood. For example, if a child starts
8 to show symptoms at a time when a younger sibling is born,
9 it's really easy for a family to say, oh well, ever since
10 the new baby arrived this child's been unhappy, whereas
11 actually it was what was happening at pre-school or school
12 that was the problem.

13
14 But very aggressive or sexualised acting out are more
15 specific. So a child who's acting out in very aggressive
16 ways is a concern. It's not - you can't say for sure, but
17 you've got to be really concerned that there's some abuse.
18 And a child whose behaviour becomes highly sexualised, a
19 very high proportion of those children are being sexually
20 abused. And, if a child shows predatory sexual behaviour,
21 that's almost always a sign of sexual abuse in my
22 experience.

23
24 Q. Is there any age group which is more or less likely to
25 show the sexualised behaviours?

26 A. No, it depends; it'll show in pre-school children, and
27 just as children get older they're more likely to conceal
28 it, whereas little children are less likely, it's more easy
29 to spot in little children, but older children obviously
30 become aware that you can't be seen to be doing these
31 things, so they become more likely to cover up.

32
33 Q. How does post-traumatic stress disorder play with
34 child sexual abuse?

35 A. Well, children often have post-traumatic symptoms, but
36 the classic post-traumatic stress disorder that most people
37 are familiar with is not so prevalent in children, that
38 they have post-traumatic symptoms, and some of them will
39 have clear post-traumatic stress disorder. But children
40 don't manifest PTSD in the same way that adults do, and
41 even if they've only got a few symptoms that can be just as
42 damaging for a child if they persist over time.

43
44 For example, hyperarousal, meaning kind of revved up
45 in your functioning, hyperarousal is just one symptom of
46 PTSD and it's not enough to make a diagnosis. But if a
47 child is continually suffering hyperarousal, that can have

1 a very damaging impact on their entire function, because it
2 means that they won't be concentrating so well at school
3 because their thoughts are racing, they won't be as
4 attentive because their attention's flickering all the
5 time, they won't be sleeping so well, that will affect
6 their growth, that will affect their energy levels. So,
7 hyperarousal being one symptom and not enough to make a
8 diagnosis can be enough to cause a huge amount of
9 disturbance in a small child.

10
11 Q. Is it more likely that that diagnosis is made as an
12 adult who suffered child sexual abuse than a child?

13 A. Adults are more likely to develop the classic PTSD
14 symptoms but even so, even in adults, PTSD is not the
15 commonest outcome; the commonest outcome is depression,
16 anxiety and then secondarily resorting to substances to
17 deal with your problems, and often post-traumatic symptoms
18 but not necessarily the full disorder.

19
20 Q. What does a classic disorder look like?

21 A. The classic PTSD consists of hyperarousal and
22 hypervigilance, so being revved up a lot; being
23 hypervigilant, so that's really mistrustful and watching
24 the environment the whole time; being preoccupied with
25 memories of the trauma, and at the same time an important
26 part of PTSD is that they're a contradictory phenomena.
27 So, while you may be pre-occupied with the trauma and can't
28 get it out of your mind, at the same time you often have
29 blanking it out as well.

30
31 Similarly, there's a contradictory approach avoidance,
32 so the contradictory phenomena, they coexist in PTSD. So
33 on the one hand there's avoidance, so you might find a
34 person who won't watch the news because they can't bear to
35 hear any reports of sexual assault, or won't read anything
36 about it or will walk away from a conversation about it.
37 So in that way they're highly avoidant of anything that
38 triggers them. On the other hand, they may be intensely
39 pre-occupied with reading about abuse, so there's a
40 combination of running away and running towards the
41 problem.

42
43 Reacting to queues, so that something quite innocent
44 can trigger a massive reaction in someone with PTSD. For
45 example, if you were abused as a child, watching a child
46 walk down the street may be enough to make you remember
47 yourself. Driving past the institution where it happened,

1 seeing someone who looks like the perpetrator; they're all
2 classic kinds of triggers. Then people will sometimes go
3 into very elaborate ways of avoiding triggers, so that
4 impacts on their adjustment as well.

5
6 Hyperarousal usually results in an inability to sleep,
7 there's often traumatic dreams, there's flashbacks, people
8 have a lot of visual imagery of what happened. And memory
9 is affected, so there's often - there's a combination
10 sometimes of amnesia for whole patches of their life, and
11 at the same time there may be intense inability to not
12 remember, you know, something that keeps coming over and
13 over and you can't get the image out of your mind. So you
14 have that strange combination of what's called hyperamnesia
15 and hypoamnesia going together.

16
17 Q. Is there any classic treatment?

18 A. Trauma treatment really is - again, there's no
19 specific treatment, there's not a specific medication or
20 specific treatment. You have to look at the person's
21 symptoms, you know, what symptoms are troubling them and
22 treat them on that basis.

23
24 So, some people are very switched off, very
25 dissociated and cut off; they will need different treatment
26 from the person who's kind of in turmoil and revved up.
27 But most of all what's important is that they need a
28 treatment process where they can establish a sense of trust
29 with the person who's treating them to feel that they're
30 believed and they're not judged and they're accepted, and
31 to be allowed slowly in their own time to be able to talk
32 about what's happened and try to put it into perspective
33 and re-examine their own feelings, because usually there's
34 a lot of guilt and shame and self-doubt that has developed.
35 So, people need a lot of opportunity to talk about those
36 feelings and it's very difficult to get rid of shame which
37 is a very fundamental disturbance.

38
39 Again, it's not a psychiatric diagnosis but it's
40 extremely damaging; children have a sense of shame. They
41 feel dirty, defiled, damaged, they blame themselves, "I'm a
42 bad child, it wouldn't have happened to me if I wasn't
43 bad". Even though intellectually as adults they get to
44 understand that it's not their fault, that sense of being
45 damaged can be very, very difficult to shift and cause a
46 lot of distress in their adult life.

47

1 COMMISSIONER MURRAY: Q. Professor, the Royal
2 Commissioners have had a very wide contact with victims,
3 not just through public hearings but through written
4 accounts and private sessions. This aspect which is almost
5 unique in a crime against a person, of taking the guilt
6 onto themselves, is a very large element in the impact
7 reports to us.
8

9 Can you elucidate a little more than you just have on
10 that phenomenon. Why is it that children who are victims
11 end up feeling guilty?

12 A. Well, because a child doesn't understand why this is
13 happening and the tendency is to think that they must have
14 caused it in some way or deserved it in some way because
15 they don't have any understanding of why this is happening.
16

17 Offenders often also will say things that lead the
18 child to believe that they're culpable as well. But there
19 is something very fundamental in little children about this
20 sense of defilement or self-blame or shame. I think
21 children, when they're treated badly, begin to internalise,
22 "I'm being treated badly, I'm bad", so that's the way the
23 child's thinking goes.
24

25 Q. Even where the adult doesn't tell them they're bad,
26 because as you know, that's been a form of abuse by carers
27 in institutions such as those you described in Western
28 Australia; even where they're not told they're bad, they
29 end up with those feelings?

30 A. Even when the offender has gone through a very
31 protracted grooming process and persuaded the child that
32 he's special and this is our special relationship, and the
33 child becomes a kind of, if you like, willing participant
34 because the grooming's been so effective. There comes a
35 point where those children too begin to feel a deep sense
36 of shame, because they become aware that they've allowed
37 themselves to be manipulated, and that brings a sense of
38 shame.
39

40 Q. As you probably realise, the Royal Commission is
41 intensely interested in counselling as a form of redress,
42 therapy, professional help.

43 A. Yes.
44

45 Q. Would you consider that the psychiatric and
46 psychological professions are well acquainted with this
47 effect and would focus on it?

1 A. I don't think there's enough understanding of the
2 problem of shame; it's not - people who are working in the
3 trauma area a lot, yes, they do understand it, but if you
4 look at generally across the board of the psychiatric and
5 psychology professions, I don't think it's very well
6 understood.

7
8 MS FURNESS: Q. Is there any difference between PTSD and
9 chronic or complex PTSD in this area?

10 A. Yes, the classic PTSD that people generally think
11 about is more likely to be the result of a time limited
12 trauma. So, if you have a car accident or something very
13 shocking happens to you, you witness a violent death or
14 something like that, then you're more likely to get that
15 what's sometimes called simple PTSD which has got those
16 classic phenomena that I just described.

17
18 That's not what's going to happen with a child,
19 because with children, the abuse is usually ongoing, it's
20 very rarely a one-off phenomenon, because the person who's
21 abusing them is usually a family member or a carer, so they
22 have access to the child over a long period of time. So,
23 child abuse is usually ongoing, it's not a one off trauma.

24
25 And because the child is developing, they're growing
26 and developing, it's part of - their developmental sequence
27 is disrupted by the abuse and, if the abuse continues over
28 a long period of time, every new phase of development is
29 being affected by the ongoing trauma. So, it ends up being
30 what we call developmental trauma or complex PTSD, because
31 it affects their personality. So now you're not dealing
32 with just symptoms, like symptoms of depression; you're
33 dealing with characterological disturbance, and so every
34 aspect of a child's function becomes disturbed; their
35 feelings, their thinking, their memory, their
36 concentration.

37
38 What's very damaging is that a child is supposed to be
39 developing a sense of who I am and what kind of person I am
40 and a sense of understanding the world and other people in
41 it, and so obviously the child's self-perception is very
42 damaged, all those feelings of shame for example are very
43 damaging to the sense of self.

44
45 Q. Are there any neurological changes?

46 A. There are brain changes that are quite clear in
47 children who have been abused. The most dramatic

1 illustration is, you know, the Romanian orphans some
2 20 years ago now I think. The orphanages in Romania were
3 full of children who were just kind of parked in the
4 orphanage and fed and watered and not much else, so they
5 had no human stimulation, no cuddling or talking, or
6 anything like that, and they were grossly retarded and
7 grossly retarded in their physical and mental development.
8 They were given a lot of battery of tests and their brains
9 were shrunk, and so what we know - it's easy to see
10 pictures of them, you can just Google them and see these
11 very dramatic pictures of brains that are actually smaller
12 than what they should be.

13
14 So, what we know is, in order for a brain to
15 development, a child doesn't just need food and water and
16 shelter; they need to be cuddled, they need to be
17 stimulated in an affectionate way, they need a lot of
18 complicated social and cognitive stimulation for their
19 brains to develop. So, if you just feed and water a child
20 and don't do much else, then their brain doesn't develop.

21
22 THE CHAIR: Q. What about, if the child is given
23 physical and emotional support, but within the place where
24 it's living, there is an abuser who abuses them; do we know
25 whether there has a neurological impact.

26 A. Yes.

27
28 Q. How do we know that?

29 A. Because a lot of brain studies have been done now that
30 show brain changes in children who have been abused. So,
31 for example, a child in a reasonably normal family who's
32 subjected to ongoing abuse, let's say by a family friend,
33 and it goes on for a period of time but the rest of the
34 family function is okay and the child's life is normal in
35 other ways, they still have brain changes.

36
37 Q. And what sort of changes can you see in those brains?

38 A. The changes affect particularly the part of the brain
39 that's concerned with memory, which is not surprising,
40 there are a lot of memory disturbances in traumatised
41 people, so the hippocampus is affected, and there are
42 changes in the volume of the hippocampus, and also which
43 hemisphere is dominant is affected. There's a middle part
44 of the brain that connects the two hemispheres and that's
45 affected. So, there are a lot of brain changes that are
46 very well documented.

47

1 Q. Are these changes likely to be greater the younger the
2 child?

3 A. Yes. A young child's brain is very, very malleable
4 because it's supposed to be, it's supposed to be a sponge
5 that just soaks up information, so it will soak up bad as
6 well as good. And also because young children are often in
7 the position of sustained abuse, because they don't have
8 much option except to stay put.

9

10 Q. Do we know whether neurological change is less likely
11 in an adolescent who's abused or not?

12 A. No, I don't think it's less likely.

13

14 Q. You don't think it's less likely?

15 A. I'm not sure, but there's plenty of studies of
16 adolescents who have been abused that show brain changes.

17

18 Q. When adults suffer trauma and are left with PTSD or a
19 version of it, do we know whether that has a neurological
20 effect?

21 A. Yes, sustained trauma in an adult will show up in
22 brain changes too.

23

24 Q. It will, in the same way?

25 A. Yes.

26

27 Q. So the brain effectively goes into retreat, does it,
28 if that happens?

29 A. Well, the brain is the organ of the mind. So, if you
30 affect a person's mind, then their brain has to be
31 affected. The thing with PTSD is there is a state of
32 hyperarousal which is a bit like an engine being constantly
33 revved which is going to have to damage the engine
34 eventually.

35

36 Q. And you can see that?

37 A. Yes, you can see that in brain changes, yes. Also
38 there are other physical changes that are very serious too,
39 which is changes to the immune system. We see a lot of
40 real illness in children who have been abused, and there's
41 psychosomatic kind of complaints, that means children who
42 are kind of showing somatic symptoms which are mainly
43 expressions of their anxiety or fear, but then there's real
44 illness; so things like ulcerative colitis and asthma,
45 there's a whole range of autoimmune diseases which are more
46 common, and children who have been abused often have
47 shorter life expectancy, up to 10-20 years shorter life

1 expectancy.

2

3 THE CHAIR: Q. When we're talking about these changes,
4 again going back to the question I asked you before, can
5 you discern whether a change is more likely in the brain in
6 a child depending upon the level of severity of the abuse?

7 A. Well, the severe abuse will usually have a more severe
8 effect, yes.

9

10 Q. But lesser abuse can have?

11 A. Yes.

12

13 MS FURNESS: Q. Can we come back to the shorter aspect.

14 A. So they're longer term effects. So the shorter
15 effects are a whole range of psychological symptoms, the
16 sort of thing that any upset child might show; so, being
17 sad, withdrawn, having temper tantrums, not sleeping well,
18 not wanting to go to school, being very emotional, so
19 bursting into tears easily, being frightened, suddenly
20 being afraid of the dark, suddenly being afraid of the
21 bogeyman coming, suddenly having bad dreams, a whole range
22 of disturbances which we call non-specific, so mostly
23 non-specific. So those same disturbances can occur under a
24 wide variety of difficulties.

25

26 Q. How does traumatic attachment feed into this?

27 A. That's where a lot of the psychological difficulty
28 arises for children. Children who are abused by someone
29 who's close to them, they usually have a bond of attachment
30 to that person. So, if it's a family member or if it's
31 someone that they're quite attached to, or that they've got
32 a significant bond, so that puts the child in a very
33 confusing position where someone I love and want to be with
34 is actually hurting me so I want to run away. But because
35 children are children, they don't have an option to run
36 away, they're held, they're really captive in a situation
37 of abuse, and so, they're in this situation which is a kind
38 of push me, pull me kind of psychological situation of
39 wanting to be with a person and then wanting to get away.

40

41 Then what is kind of perverse in the way we function
42 under those circumstances and really positions us for more
43 damage is that, the more distressed a child feels, the more
44 likely it is to want to cling to someone. So, we all do
45 that, if we're upset, we want contact, we want soothing, we
46 want someone to take care of us. So, if you're very
47 distressed you're actually likely to become more clingy

1 and, if it's the person that you're attached to who's
2 abusing you, then you're positioned for more abuse.

3
4 It's like the well-known situation of the kicked dog
5 that clings to its master, so it's common in animals as
6 well as human beings that creates that paradoxical
7 situation where people are attached to their abusers.

8
9 Q. Can we turn to the long term impacts, dealing firstly
10 with psychiatric disorders.

11 A. As I said a little while ago, there's no particular
12 psychiatric diagnosis that attaches to the long term
13 outcome of childhood sexual abuse. There's almost any
14 psychological or psychiatric diagnosis you care to name has
15 the --

16
17 Q. What's the more common?

18 A. The commonest ones are depression, anxiety, and in our
19 culture substance abuse which is a phenomenon of our
20 culture really because we tend to see drugs and alcohol as
21 a way of dealing with our upset feelings. But also heavy
22 reliance on prescription drugs is another one because that
23 also is a phenomenon of our culture, that we tend to go to
24 the doctor and get a pill if we're feeling bad, so there's
25 a lot of dependency on medication and substance abuse. But
26 depression and anxiety are the commonest ones, which
27 unfortunately, because they are the common psychological
28 presentations, don't necessarily alert people who aren't
29 familiar with dealing with this, and so, sometimes it's
30 just saying, "Oh, the person's depressed", and maybe not
31 enough effort's made to look into it.

32
33 But personality disorder of all kinds is common,
34 because as I said before, a child in an ongoing situation
35 of trauma, their entire development is affected, so the
36 character is affected. So they show characterological or
37 personality disturbances; usually disturbances in
38 relationships and disturbances in sexual adjustment and
39 sexual identity. Young boys who have been abused by a male
40 offender over a long period of time are often very confused
41 about their sexuality. They often assume that, because a
42 male offender's had sex with them over a period of time,
43 that that means that they're homosexual, where they may not
44 be, so they become quite confused about their sexual
45 orientation.

46
47 They can become very hypervigilant around other men,

1 so not comfortable in a situation where they're dealing
2 with other men. And having difficulty establishing a
3 functional sexual relationship, having difficulties with
4 intimacy. Again, you've got the contrast of, some people
5 just get switched off sex and other people become sexually
6 hyperactive. A child who's been sexually stimulated before
7 they're ready for it can sometimes go on to have excessive
8 sexual activity. And, when they become adolescent, and
9 here's where the psychological abuse feeds into the sexual
10 trauma, feeling angry with the world and betrayed and all
11 those terrible feelings that they have, an angry young
12 teenager who's been abused is likely to use prostitution
13 and be re-victimised.

14
15 Q. So use prostitution, become a prostitute?

16 A. Well, use prostitution often as a well to get drugs
17 and money, and there's often a perverse kind of
18 gratification; it's kind of like, "I've been used and now
19 I'm going to use these people to get money". Often they're
20 terribly exploited by pimps and people like that because
21 they're young and can be exploited, and often they're drug
22 using and so sex work is a way of sustaining their drug
23 use. And of course, they're likely to - young girls are
24 likely to get pregnant and teenagers that have sex are much
25 more likely to get sexually transmitted diseases, so you
26 get a whole calamity that follows because of what's
27 happened to them.

28
29 Q. You referred to people as sleepers, that is, those who
30 don't respond to or understand or realise that they've been
31 abused until much later in life. Is the treatment that's
32 given to them different from those who disclose earlier?

33 A. No. If I see a child who seems to be showing no
34 symptoms and yet we know that they've been abused, after a
35 careful evaluation, if they do seem to be functioning well,
36 then what we do is counsel the parents to keep a watching
37 brief over them really, and then if there difficulties that
38 arise, then to seek further evaluation immediately. But if
39 the child seems to be putting it behind them and getting on
40 with their life, then there's no benefit really in trying
41 to force the child to think about something bad.

42
43 Q. You've spoken of sexuality and the consequences that
44 it can have on a person's sexuality. What about sexual
45 offending?

46 A. Yes, there are a small - there are a proportion of
47 abused children who will go on to become offenders

1 themselves. It's a source of enormous pain and anxiety
2 because most people who have been abused kind of live in
3 fear and dread that somehow it's contaminated them, it's
4 taken them over, that it will come out in them so they
5 often - and that's very sad because it often makes them
6 unwilling to have good relationships with their own
7 children, they kind of hold back from their children the
8 whole time, as if they're afraid that this thing's going to
9 come out of them in some way.

10
11 But there are a proportion that do go on to become
12 offenders - not the majority by a long shot. Adolescents
13 who are being sexually abused are more likely to become
14 offenders, because they're abused at a time when all
15 adolescents are kind of more sexually aware and have much
16 more sexual drive developing, and so they can become - they
17 get kind of flashbacks of the abuse and then it's very hard
18 to know what's a flashback and what's a sexual fantasy, so
19 they may end up enacting the very trauma that they
20 experience themselves; whereas little children who are
21 sexually abused are much less likely to have any genuine
22 sexual feeling or have any sexual fantasies or sexual drive
23 of any sort and so it's less likely to affect them that
24 way.

25
26 Q. Is that based on your clinical experience or research
27 that's been undertaken?

28 A. Both.

29
30 Q. And they're consistent, your experience with the
31 research?

32 A. Yes.

33
34 Q. In terms of those who have the fear that you have
35 described, is there anything they can do to alleviate that
36 fear?

37 A. Well, I think trauma counselling will help them to
38 understand why they're having the feelings they're having
39 and to also understand that an impulse doesn't have to be a
40 behaviour; that you can have a fantasy or an idea, but you
41 can still have adequate control of yourself; it's not like
42 something that's going to just leap out.

43
44 Q. That you can resist it?

45 A. Yes. Yes, that's an important part. Well, first of
46 all to realise that a flashback is different from a
47 fantasy; that's difficult, because people who have been

1 abused have flashbacks, so a picture comes into their mind
2 of the sexual act that they experienced, but ordinary human
3 beings have sexual imagery all the time and so it can be
4 very confusing for the trauma survivor to know what's a
5 flashback and what's sexual imagery.
6

7 Q. And trauma counselling is a good approach?

8 A. That's very important to help them understand what
9 precocious sexual stimulation has done to them, and
10 especially to realise that they're not in the grip of
11 something that's just going to take control of them and
12 push them in a direction they don't want to go.
13

14 Q. Does trauma counselling refer to a person who's got
15 expertise and qualifications in that area?

16 A. Yes, trauma - we usually refer to trauma-informed
17 services or trauma-informed counselling, which is having a
18 thorough knowledge of trauma and the effects trauma has on
19 people and being able to incorporate that into your
20 treatment. And it's not a specific treatment, so there are
21 a variety of counselling approaches and a variety of
22 psychological techniques that are used in counselling, but
23 if it's trauma-informed, then it takes account of what's
24 happened to this person and what effect it's likely to
25 have, and understands how treatment can be traumatising in
26 itself and how to avoid that; that people who have been
27 traumatised need to feel safe, need to feel trust, they
28 need to be able to go at a pace that they can handle and
29 not a pace that's imposed on them.
30

31 It's really important that they don't feel abused by
32 the therapy, and I'm afraid psychiatry has been abusive in
33 the past at times, especially by imposing treatments on
34 people that they don't necessarily want so they feel abused
35 by the treatment itself. So trauma-informed counselling
36 means understanding all of those difficulties.
37

38 COMMISSIONER MURRAY: Q. Professor, this has been
39 reported to us as a problem: what happens to victims and
40 survivors of these crimes is, they're referred to
41 counselling by an institution or by their doctor or
42 whatever, but they themselves aren't equipped to know
43 whether that person who's going to counsel them is
44 trauma-informed, and many of them have reported to us that
45 their counselling experiences have been thoroughly
46 unsatisfactory.
47

1 I said to you earlier that the Royal Commission is
2 very interested in the area of counselling therapy for
3 victims and survivors. Is there anything you'd say to us
4 about how victims and survivors could be much better
5 directed to those who could provide them the best care? Is
6 there some sort of process or improvement which you could
7 indicate to us might be helpful?

8 A. Well, I think it's important that the person that
9 they're seeing has had some kind of postgraduate exposure
10 to trauma - to education about treating traumatised people.

11
12 Q. But how would they know? You see, that's the
13 difficulty; if they're directed, how would they know that
14 they're going to the people who can actually help?

15
16 THE CHAIR: Q. Professor, I think the suggestion has
17 been that the professional bodies should accept the
18 responsibility of accrediting people. Do they have any
19 accreditation process at the moment?

20 A. No.

21
22 Q. Would it be difficult to organise for that to happen?

23 A. The professional bodies ought to be really doing much
24 more continuing education in this area. There is some
25 going on but not nearly enough, it should be routine.

26
27 Q. So in terms of education, and then the representation
28 would be through accreditation?

29 A. Yes.

30
31 Q. Is that feasible, could we think of the profession
32 organising itself to do that?

33 A. It's not difficult for the professional bodies to
34 mandate a certain amount of trauma training in continuing
35 education. Continuing education is specified, it's
36 compulsory. It would be - you've got to do about 100 hours
37 of continuing education every year. It would be very easy
38 to make sure that 20 hours of that 100 hours is done in
39 some sort of trauma-informed service.

40
41 Q. Would that mean that those people who undertake that
42 level of professional training would be entitled to say to
43 the general community, "I have this level of knowledge and
44 experience that I can deal with this sort of trauma"?

45 A. Well, it's up to the professional bodies how they want
46 to do that; whether they want to say, well, that's part of
47 our ongoing - our continuing education program, so we

1 certify this person is in a continuing education program,
2 therefore they're up-to-date, or whether they want to have
3 some kind of certificate or recognition of some kind.
4

5 Q. Which would you suggest would be the best way to go?

6 A. I think probably having it as part of the continuing
7 education, because it depends whether the training bodies
8 are interested in doing this. It would be nice if they
9 were. They ought to be, because it's such a pervasive
10 problem.
11

12 Q. We might be able to move it along a little.

13 A. Well, if you are able to move it along, then I think
14 that it ought to be absolutely part of the training
15 programme.
16

17 Q. Part of the fundamental training programme?

18 A. Yes, it ought to be part of that.
19

20 THE CHAIR: We'll do what we can, professor.
21

22 MS FURNESS: Q. Part of the training as well as
23 continuing education?

24 A. It ought to be part of the training program, yes.
25

26 Q. Including on the ongoing requirement for 100 hours
27 a year, it would be part of that as well?

28 A. Well, I think, yes, because it's a growing field; it
29 would be important to remain abreast of it.
30

31 THE CHAIR: Q. Professor, from this community and
32 others, there are great concerns about the level of suicide
33 in people who have been abused, and no doubt you've
34 considered this topic. The starting point for the
35 discussion is this question: firstly, I assume you accept
36 that numbers of people who have been abused end up
37 committing suicide?

38 A. Oh, absolutely, it's well documented, yes.
39

40 Q. Is the mechanism by which that occurs because that
41 person may have had triggered a depressive illness by
42 reason of the abuse and then the depressive illness is the
43 pathway to suicide, or is there a direct relationship
44 between abuse and suicide?

45 A. Well, there's a very strong relationship between abuse
46 and suicide, a very strong relationship.
47

1 Q. Is that through the depressive illness?
2 A. It's through a variety of things. Severe depression
3 is often part of the consequences of trauma, and then, as I
4 said, often there's substance abuse as well, so it's very
5 common that people who are chronically depressed and
6 traumatised then turn to drugs or alcohol; and then drugs
7 and alcohol have a depressogenic effect anyway, and also
8 will exacerbate the person's negative thoughts, so they go
9 on a binge and then they wake up and just think, "Well, I'm
10 useless anyway and look at the life I'm living and I'm good
11 for nothing", and they feel damaged and they feel ashamed,
12 and then they feel ashamed at the way they're dealing with
13 their problem, and so that compounds as well. Sometimes
14 they're plagued by symptoms, that they just can't stand the
15 symptoms any longer.

16
17 Q. The symptoms of?

18 A. Symptoms, say, flashbacks and intense preoccupation
19 and feeling tormented by memories, and sometimes that will
20 be what will drive a suicide. But there's no one kind of
21 situation, there are lots of factors.

22
23 Q. But it's right to think that we should be concerned
24 that one of the outcomes for people who have been abused is
25 suicide?

26 A. Absolutely, and I think that that shame and self-blame
27 thing that's so fundamental feeds into that because, if you
28 feel like "I'm a bad person", it's easier to think about
29 killing yourself.

30
31 THE CHAIR: I think we might take a short adjournment now
32 and come back after a short break. We'll adjourn.

33
34 **SHORT ADJOURNMENT**

35
36 MS FURNESS: Q. Dr Quadrio, are there any specific
37 effects from abuse by a clergy on a child or subsequently
38 an adult's view of spirituality?

39 A. Yes. That's a very important aspect and a particular
40 aspect of abuse within a religious context because,
41 especially with young children, see a priest or a member of
42 the clergy as someone's who's close to God really, and so,
43 the sense of betrayal is particularly shattering because
44 it's kind of like, not just one bad person, but it feels
45 like, well, maybe God's bad. The loss of faith and
46 shattering of the belief is really very damaging to a
47 child.

1
2 If a child grows up feeling, well, you can't trust
3 anybody and everybody's bad, and even God's bad, that's
4 what I mean about the profound characterological damage
5 that can have.
6

7 And also, it's very important because usually the
8 child's family or their entire community may be strongly
9 affiliated with this particular religion, and that means
10 that when children make disclosures they very often get a
11 bad reception and told they're lying, it can't be true.
12 The negative response from family and community can really
13 compound the damage enormously.
14

15 Q. What about when a child is asymptomatic and then the
16 sleeper effect applies and they remember and disclose much
17 later on; does that have a similar effect on their
18 spirituality?

19 A. Yes. Yes, it does. The long delay doesn't make any
20 difference, it still shatters one's belief. It's very
21 disturbing to the sense of identity, because you may have a
22 child that's been abused, let's say for argument's sake,
23 maybe between the ages of 5 and 7 and then they go into a
24 period of four or five years where they seem to be going
25 okay, they don't even think about it anymore, and then
26 something triggers it and it all comes out. They also have
27 this very damaging experience of, it's as if that part of
28 my life is just false, that whole part of my life is just a
29 lie, the whole thing, so everything that they established
30 as part of their identity just suddenly falls away from
31 them because they just feel like it's not only abuse years,
32 but all the subsequent years suddenly just seem to mean
33 nothing anymore, and so they can profoundly - have a sense
34 of alienation from themselves, which is really damaging to be
35 feeling alienated from yourself.
36

37 Q. Just before the break you were giving evidence about
38 suicidality and the increased number of suicides from
39 people who were abused as children. Leaving that to one
40 side, what other effects are there on the longevity of
41 those who have been sexually abused as children?

42 A. They don't live as long as children who have not been
43 traumatised. So trauma has, it's not just the
44 psychological damage, it's the real physical damage; so
45 they have more illness, they have more real illness. On
46 top of that, they often have unhealthy lifestyles, so
47 they're prone to substance abuse and poverty and

1 unemployment, so they're factors that are on top, and all
2 of that adds up to something like 10 to 20 years less life
3 for a child who's been traumatised. So there's an enormous
4 morbidity in terms of physical ill-health and psychological
5 ill-health.

6
7 Q. You've referred to grooming throughout your evidence
8 this morning. What are the particular and more common
9 characteristics of grooming?

10 A. As I said, the children in institutions often aren't
11 particularly groomed because they're already captive, they
12 don't need to be groomed, sometimes they are just subject
13 to the authority of the offenders. In the community the
14 grooming, you can see grooming that's really quite
15 complicated and there can be very careful grooming.
16 Features for example, often there's very careful grooming.
17 And the grooming is not just grooming a child. We talk
18 about grooming in the family, grooming in the community, so
19 an offender can establish themselves as a very, very
20 respected and maybe much loved member of the community or
21 the school or the organisation and they go to a lot of
22 trouble to really establish themselves in that way.

23
24 Children abused by clergy, often the clergy befriend
25 the family, visit the family, have dinners in the family
26 home, all of that is part of really establishing themselves
27 very firmly, so that, when the disclosure comes, the
28 immediate reaction is, no, it's not true.

29
30 Q. You've indicated earlier that there's no one profile
31 of an offender who's a sexual abuser. What characteristics
32 are there, however, that apply to offenders of the
33 children?

34 A. There's no particular profile. They are attracted to
35 areas where they will have access to children. Obviously
36 if a person has that kind of sexual interest they will want
37 to work with children, so they are attracted to areas where
38 they have access to children, and they're often quite adept
39 at grooming the community and grooming the organisation so
40 that they're quite well respected and often quite
41 functional in their jobs, they're not dysfunctional in any
42 way, they might actually be very good at their job so that
43 they're quite respected in what they're doing.

44
45 Then looking at their sexual orientation itself, a
46 considerable number of them will be what's sometimes called
47 a true paedophile, in that they're exclusively attracted to

1 children, they're not interested in other relationships.
2 Some will abuse children but also have adult relationships
3 as well. That's sometimes true of ministers in the
4 community - not so much obviously with a Catholic priest
5 it's not so true.
6

7 Q. Sorry, true of?

8 A. Ministers in the community. Often they will have
9 relationships in some of the religions where priests can
10 marry, they marry but are still abusing children. But the
11 majority that you see, especially in the Catholic context,
12 tend to be people who really have fairly much an exclusive
13 orientation towards children.
14

15 There's a reasonably higher level of substance abuse
16 amongst offenders, so they're often using, alcohol usually;
17 I mean a socially accepted substance abuse, if you like,
18 rather than recreational drugs or anything like that. But
19 yes, they don't have any particular profile, and they are
20 not particularly psychopathic either, so they don't come to
21 anyone's attention for breaking rules in other ways or
22 breaking the law, and they usually are very good at
23 establishing themselves and being accepted.
24

25 Q. You've spoken in terms of the true paedophile. Are
26 there also opportunistic offenders?

27 A. Yes, there are.
28

29 Q. How do they work?

30 A. If people don't have access to a regular kind of usual
31 sexual relationships. For example, in prison, men in
32 prison have sex with each other who wouldn't be the least
33 bit interested in sex with men when they're out of prison
34 but that's in a situation where they don't have any option.
35 Or sometimes, if people are having contact with children,
36 where it hasn't been a particular predilection of theirs in
37 the past, the fact that the children are there and there's
38 a lot of physical contact with them, they find that the
39 opportunity has arisen and they take advantage of it, but
40 they may not be people who normally seek out children to
41 have sex with.
42

43 Q. Are there any other characteristics?

44 A. Sometimes offenders are people who are not functioning
45 well, but that's a minority. Ones who are not functioning
46 well, not getting along well and sort of immature and turn
47 to a relationship with a child because they're not feeling

1 able to conduct a more adequate relationship with another
2 adult, but they do tend to be the minority.

3

4 Q. And that's a general immaturity, emotional and sexual
5 immaturity?

6 A. Yes.

7

8 Q. You, I understand, have been involved in some
9 treatment programs for offenders in the past?

10 A. Yes, I worked in the prisons for a number of years and
11 we had offender programs in New South Wales, there was a
12 number of offender programs, so I'm familiar with the
13 offender programs that we have.

14

15 Q. The current offender programs in New South Wales?

16 A. Yes.

17

18 Q. How successful are there?

19 A. Not terribly, I have to say. The difficulty, and it's
20 especially difficult in religious contexts, is that, in
21 order for someone to be a good prospect for rehabilitation
22 they need to be willing to admit what they've done and to
23 have some genuine sense of remorse or contrition and to be
24 motivated to do differently. And these people don't fit
25 into that category; usually, by the time it comes to light,
26 their usual reaction to the disclosure is to deny it, "No,
27 it didn't happen". Then usually after that there comes
28 vilification of the victims, so "the victim's lying, the
29 victim's bad, the victim's manipulative, the victim's
30 whatever". So by the time you've been protesting your
31 innocence for a long time and then vilifying the victim,
32 you're not really the ideal person for rehabilitation who's
33 supposed to be willing to admit what they've done and feel
34 some contrition for it, so it's very hard to come back from
35 that position that you've got yourself into.

36

37 It's true of offenders outside the church, the usual
38 reaction is denial and blame the victim, and that's not
39 good prospects for rehabilitation, and even if you do get
40 them into the rehabilitation program, in the case of people
41 who really have an exclusive orientation towards sex with
42 children, it's very hard to change people's sexual
43 orientation, and you really need to have someone who's
44 motivated to change, so it's not easy.

45

46 Q. What form of treatment are you talking about?

47 A. In the prisons in New South Wales they use an offender

1 program which is about, first of all, trying to move the
2 offender into the position where they accept responsibility
3 for it and stop blaming the victim; they accept that it was
4 entirely their own responsibility; trying to get them to
5 develop empathy, have some sense of the harm that they've
6 done and what the victim must have experienced; and then to
7 focus on ways of changing their behaviour and ways of
8 having more adaptive relationships, but it's not easy.

9
10 Q. Do you keep success rates in relation to offending of
11 those in prison?

12 A. The success rates are not good.

13
14 Q. Are they indicated by them leaving prison and whether
15 or not they're back in the prison system for similar
16 offending?

17 A. In order to get into one of these programs you already
18 have to be totally committed to rehabilitation, so that
19 eliminates actually a whole lot of them, and you have to be
20 willing to admit guilt, and that eliminates quite a few.
21 About 50 per cent of people in prison tell you that they
22 didn't do it, whatever it is that they've been convicted
23 of, they didn't do it, and that's certainly true of sex
24 offenders, they didn't do it or the child lied or whatever.
25 So you get down to only a minority who will accept
26 responsibility and commit themselves to a treatment
27 program.

28
29 Q. And the treatment program involves intensive
30 counselling?

31 A. Yes, they have treatment - an offender program they go
32 into and it's about four months, the program, and then, if
33 they complete the program, then they're eligible for
34 parole.

35
36 Q. When you indicated the success rate was low, is that
37 because there is a percentage of those who, when released,
38 commit similar offences and then come back in?

39 A. There's a significant recidivism rate, and we've
40 already selected out the best prospects, and even with
41 those best prospects people, there's a significant
42 recidivism rate, yes.

43
44 Q. You left the prison system in the early 2000s?

45 A. 2001 I left, yes.

46
47 Q. What's changed from then till now in terms of offender

1 treatment?

2 A. Not a lot.

3

4 Q. No new learnings?

5 A. Look, I think the programs are fairly similar. The
6 difficulty is, the prisons are getting fuller and fuller,
7 so it's harder and harder to deliver good psychological
8 services. There's an awful lot of mental health morbidity
9 in prisons. The majority of prisoners have been sexually
10 abused as children, so if you wanted to deal with complex
11 trauma in a prison, you'd need an army of psychologists to
12 move into the prisons, because the incidences of child
13 abuse and trauma in their backgrounds is enormous; it's
14 something like 60 to 80 per cent.

15

16 Q. That's based on both research and your experience; 60
17 to 80 per cent?

18 A. (Witness nods).

19

20 Q. And that's sexual abuse as a child?

21 A. Developmental trauma.

22

23 Q. Familial and institutional?

24 A. Both. Most of the men in prison have had traumatic
25 childhoods, either physical, sexual, psychological abuse of
26 some sort; it's very prevalent. It's just one of those sad
27 things. One of the difficulties that really is a huge
28 difficulty in our society is that, for whatever reason -
29 and it's very complicated, I won't go into it - for
30 whatever reason little boys seem to be predisposed to
31 become externalisers and little girls are predisposed to be
32 internalisers; meaning that, if a little boy's upset he's
33 more likely to show it in an overt way, become overactive,
34 become temper tantrums, become something, acting out,
35 externalising. Little girls are more likely to
36 internalise, meaning getting sad, scared, withdrawing, that
37 sort of thing. It's not exclusive, boys can be withdrawn
38 and girls can be angry, but it tends to be a very strong
39 difference.

40

41 The problem with that is that, by the time a boy's
42 11 years old and externalising, people just see him as a
43 bad kid and then he's set for delinquency in the prisons.
44 And a little girl at 11 is seen as sad, fearful, anxious,
45 whatever, and she's set for psychiatric services rather
46 than the prison. And it's really sad because we end up
47 with a huge amount of mental health difficulties in men

1 being channelled into prisons where there's not adequate
2 rehabilitation services and not adequate treatment and
3 11 per cent of men in prison have got a psychotic illness,
4 which is not a place to be treating someone with a
5 psychosis, and most of those men with psychotic illness
6 have got a history of childhood trauma.

7
8 So it's just one of those sad things about the way our
9 society functions that, once you put the "bad" label on a
10 boy, it sticks, and once he does something really bad, like
11 hurt someone, then any sympathy or understanding of his
12 trauma gets lost and it's just thrown - lock him up and
13 throw away the key is the general feeling in the community.

14
15 Q. You gave evidence earlier about the effect of trauma
16 on the development of the brain, including memory, and you
17 also gave evidence about flashbacks. In your clinical
18 experience, does repressed memory play any role in people
19 seeing you who have been abused sexually as children?

20 A. Memory is a really important part of trauma. I think
21 I said earlier, the strange thing about trauma is, there's
22 this combination of remembering too much and not
23 remembering enough. So there will be patches of memory
24 missing and then there will be experiences that just are
25 burned into the mind and the person can't get rid of them,
26 and it varies. Some people are just full of imagery and
27 are tormented by it and other people have huge blanks.

28
29 There's been a lot of controversy in the area of
30 memory, a huge amount of controversy. So there's
31 suppressed memory, repressed memory and recovered memory.
32 First of all, we have to accept that part of the definition
33 of what trauma is about is that it's a disturbance of
34 memory, so that's fundamental, that there is some
35 disturbance of memory in trauma.

36
37 Recovered memory is a very controversial area where
38 people have claimed to have absolutely no memory whatsoever
39 of the abuse and they go into treatment or counselling and
40 suddenly it comes back, and there have been instances where
41 it's been suggested by the therapist and so then the whole
42 area became muddied with accusations. Of course, you're
43 dealing with a community that's very quick to discredit the
44 victims anyway, and some of it probably has been bad
45 counselling, but the context of course is that the
46 community's always willing to discredit the victim, so it
47 easily becomes a case of, that's recovered memory so don't

1 count any of that.

2

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What I see a lot of is what I think you call suppressed memory. There are a lot of people, and boys more than girls, who just decide I'm not going to think about that, I'm putting it out of my mind, I'm just going to get on with my life, I'm not going to deal with this, and some people can do that more effectively than others. So in that case it's a suppressed memory. You may then get the situation where the person said, "I forgot all about it", and then something's happened to trigger it. But if you sit down and very carefully go over it with them, you find that they never actually didn't know that it happened, they've just managed very effectively to not think about it at all, maybe for years and years and years. But if you go over it carefully, you find that actually they always did know. If you'd ever sat down with them and said, "Well listen, what happened when you were 7 years old and going to boy scouts", they would have said, "Oh, yeah, well I remember", but they just haven't given it any thought, so it's suppression.

Then repressed memory is a bit more complicated, that's supposed to be a psychological mechanism. It's a controversial area, whether your memories can actually be deliberately buried as a way of protecting yourself. There are some people who think that repression is possible and others who don't. But certainly suppression is very common. I mean, ordinary people do it every day, we all do it, we always say, "Look, I'm not thinking about that, nothing I can do about it, I'm not going to think about it anymore", and if you can do that effectively, then some people can actually put something behind them and move on

Q. That would affect significantly when, and indeed if, a person discloses what happened to them as a child?

A. Yes. It's more likely that the disclosure will come - sometimes it comes as a shock to the person because they have spent so much of their life keeping it buried and not thinking about it, and then once they start to talk about it, they sometimes feel shocked themselves of the intensity of what they're feeling, and that's when people will often say, you know, "I'd forgotten all this", but you actually hadn't forgotten it, you actually had found a very effective way of keeping it completely bottled up. Sometimes it's totally bottled up, there's no evidence that the person's troubled. Other times they say it's bottled

1 up but it's actually leaking out in little ways that you
2 can see. Little ways like, they never stay in a
3 relationship very long, or they don't relate very well to
4 their children, or you know, it's leaking out if you like
5 in those ways but they don't put it together in their
6 minds. They don't stop and think, well, the reason I'm not
7 getting very well in my life is because of all of that.
8

9 Q. In your evidence so far you've spoken of the need for
10 trauma-informed counselling and those who have sufficient
11 skills and qualifications at it; you've spoken of the need
12 for more mental health resources in prisons for those who
13 have been abused as children. What other areas of support
14 do you think survivors need?

15 A. We have to be much more mindful of symptoms in
16 children than we are as a community. It's a very common
17 scenario that I see; I see kids who are troubled, and in my
18 experience they tend to be about 11 years old by the time
19 they get to see a psychiatrist, and then you sit down and
20 go into it and you find out that this little kid was banned
21 from pre-school for biting other children, and the family
22 just felt embarrassed and ashamed, which compounds the
23 child's feelings of shame, and just moved to another
24 kindergarten. Then you get this history of all these
25 little phenomena over the years, and people have said,
26 look, he's just a hyper kid he's got ADHD, he's got this,
27 he's got that, he's got dyspraxia, he's got learning
28 disorders, the labels proliferate and the treatments
29 proliferate and the medication proliferates, and nobody
30 really stops and thinks, something's happened to this kid.
31 And by the time they're 11 years old it can be really hard
32 to turn them around.
33

34 That's what's really sad about boys because by the
35 time they're 11 they're angry and they're big, and now
36 people are starting to feel intimidated by them and the
37 general approach then is, you know, put him away somewhere,
38 and you've missed the boat because we need to deal with
39 these kids when they're littler, when they're already
40 symptomatic, and not say, this is just a bad kid or this is
41 just ADHD or this is just a hyper kid or this is a reaction
42 to cordials, or whatever theory of the day happens to be
43 around, and there's always a theory of the day.
44

45 Q. Those children would probably see GPs as a first port
46 of call, so it's GPs who need to be made better aware of
47 symptoms that might indicate some underlying abuse?

1 A. The whole community needs to be aware that when
2 children are symptomatic, there's a reason. Children are
3 actually very rational creatures; they're not irrational
4 creatures. There's a tendency to say, he or she is just a
5 child, you know. Children are very rational creatures. If
6 you stop and think about why is this child symptomatic and
7 why have they got these particular symptoms, then usually
8 there's something there.

9
10 Q. In addition to GPs, it may well be teachers who would
11 be able to observe this behaviour in children?

12 A. I think the community generally, teachers,
13 psychologists, counsellors, GPs, there needs to be just a
14 huge amount of awareness that children who are troubled are
15 troubled for a reason. There's so much gobbledygook going
16 on about this disorder or that disorder or this allergy or
17 that allergy or whatever, and sometimes it is, but an awful
18 lot of child distress gets ignored or covered up, or gets
19 channelled into all kinds of treatments.

20
21 Q. So, looking then at trauma-informed counselling, you
22 were asked questions earlier about the need for some form
23 of accreditation system so that survivors know that they're
24 going to see somebody who's properly qualified and
25 experienced. Are there any other forms of counselling that
26 would provide a similar service for survivors?

27 A. There are a lot of survivor organisations that are
28 very helpful. The support that people get from other
29 survivors is really important. Finding other people who
30 have been through the same experience is a great comfort,
31 it makes you feel like you're not alone, and also, you have
32 people you can talk to who really do understand what you've
33 been going through, so survivor organisations are very
34 helpful. And also, survivors get to be clued up about who's
35 who in town and who you can talk to and who you can't talk
36 to, so you get good advice from other survivors about which
37 psychologist to see and which not to see, and which doctor
38 to go to and which not to go to, so all that's really
39 important for the survivors. So I think the organisations,
40 the self-help and support groups, have been really good,
41 and also the support groups have been wonderful in lobbying
42 the professions to change what they're doing.

43
44 Q. In your clinical experience, do you think survivors
45 would feel discomfited by going to see someone when that
46 someone was paid for by the institution where they were
47 abused?

1 A. Yes, that's been one of the problems of attempts at
2 redress made by the institutions. I think you have to get
3 the help - maybe the institutions can pay the bill, but
4 that's all. They shouldn't be providing the treatment, no.
5
6 Q. So they provide the money and there's an independent
7 administration as to --
8 A. Absolutely.
9
10 Q. -- funding of counselling and the like as well as any
11 redress?
12 A. It's a bit like psychiatric research is run by drug
13 companies and that's, straight up, you know the results are
14 going to be skewed, and they are; the same thing. It has
15 to be separate from the money, otherwise it gets skewed.
16
17 Q. In addition to having a clinical practice and doing
18 the research and speaking engagements that you've spoken
19 of, do you also do assessments of offenders for courts?
20 A. Yes.
21
22 Q. Who approaches you to do those generally?
23 A. I did most of it when I was in prison - not when I was
24 in prison, when I was working in prison. Since I've been
25 out of prison, I do them occasionally, but I don't do a
26 lot. I've got a reputation for being on the side of the
27 victims and that compromises me.
28
29 Q. I was wondering about that. So who approaches you
30 generally now?
31 A. Sometimes I am approached to assess, yes, more often
32 with familial abuse.
33
34 Q. Do you consider that an important part of your work in
35 the profession as providing that service?
36 A. I always felt it was really important - I was
37 interested in the prison situation because, seeing the
38 amount of trauma in prisons is really important, so the sex
39 offenders are difficult to help, but in prison the sex
40 offenders aren't the big group; the big group of offenders
41 in prison are other kinds of offenders, so it's been
42 important to work in that context, to see the effect of
43 trauma on their trajectories. As I said, I do a lot of
44 family assessments and that brings me into contact with
45 family members who abuse other members, and children who
46 abuse other children and adolescents. But the
47 institutional abuses, no, I'm not the favourite person to

1 assess them.

2

3 Q. Do you think that survivors might feel difficulties in
4 being counselled by somebody who also provides assessment
5 for offenders?

6 A. I think it needs to be kept very separate.

7

8 Q. And it's not necessary for your ongoing development as
9 a psychiatrist to have that component, just using you as an
10 example, in your work?

11 A. I thought it was necessary for me to have that, and I
12 think it's necessary in one's training to have both so that
13 you don't just see one side of this.

14

15 MS FURNESS: Thank you. Thank you, Your Honour, I have
16 nothing further.

17

18 JUSTICE COATE: Q. Doctor, can I just take up with you a
19 couple of issues that you've spoken about. You've talked
20 in general terms about what we've come to understand as the
21 various barriers to children disclosing, so you've given
22 evidence about those feelings of shame and guilt. Can I
23 ask you just to focus for a moment on the issue of children
24 worrying about not being believed. We've heard a
25 considerable amount that, as being a barrier to disclosure.

26

27 In child developmental terms, what do you think is
28 going on for the child who is concerned that he or she
29 won't be believed if they disclose?

30 A. I think children are intuitively correct, they have an
31 awareness and they're correct because children are often
32 not believed, and they certainly have an intuitive
33 understanding of what their parents will and will not
34 accept, so there's that kind of intuitive level of
35 understanding.

36

37 The children who do disclose often will realise that
38 they've got parents who are going to be supportive, but if
39 a child intuitively realises that the family's not going to
40 be willing to listen, then they won't disclose and then the
41 shame and the guilt and the self blame is also part of
42 that.

43

44 Q. So, is it your view that part of that is the impact of
45 what we've been referring to this morning as the grooming
46 process?

47 A. Well, for example, the child might be well aware that

1 their parents admire the offender - in the case of the
2 church for example, if mum and dad are firm believers in
3 the church and committed to the faith, then the child
4 realises that it's very hard to destabilise that system and
5 that mum and dad probably won't want to know about this.
6 If there's been grooming of the family, like when the
7 offender has actually become a visitor to the family home
8 and that sort of thing, it becomes very difficult.

9
10 Q. Thank you. Again, with respect to the grooming
11 process, we've heard a considerable amount of evidence
12 about denigration, humiliation and physical abuse being
13 perpetrated on children in conjunction with sexual abuse.
14 Is it your opinion that those forms of abuse are part of
15 the grooming continuum or are they part of something else
16 that's going on?

17 A. When there's frank physical abuse, it's usually
18 children who are in care, and in that case there's much
19 less grooming that goes on because the child's under the
20 control and the authority of the offender, so they don't
21 have to - they can just force what they want on the child,
22 so there's not much grooming that goes on there.

23
24 Some of the institutions, especially the ones
25 that - -

26
27 Q. The schools.

28 A. Yes, and also especially looking at institutional care
29 of children prior to the last maybe couple of decades when
30 corporal punishment of children was much more widely
31 accepted, and so, children would be punished physically,
32 sometimes just for not complying with the authority of the
33 offender. I think in the last couple of decades there's
34 much more of a consciousness in the community that corporal
35 punishment is not a way to go with children.

36
37 But in the days, for example of the Christian Brothers
38 that I saw in the 40s and 50s, corporal punishment was just
39 standard, it was standard in schools, even in good schools
40 it was standard to punish children physically.

41
42 Q. Just a completely separate question: in the course of
43 responding to Ms Furness's questions you've said that, I
44 think it was the 2008 Sydney conference, you said that some
45 of the faiths said they didn't have a problem. Are you
46 able to tell us which ones they were that took that view?

47 A. Well, they've since all had media exposure for having

1 the same problems.

2

3 Q. Yes, but which ones in particular do you recall?

4 A. At the time we approached the Jewish organisation and
5 they didn't, and the Muslim ones that we approached said
6 that they didn't have a problem too.

7

8 Q. Can I take you now to resilience, and I think you've
9 given evidence to us about what you've called innate
10 resilience. I understood you to say to us generally that
11 it was your view that resilience in a child was not
12 particularly well understood by your profession at this
13 stage.

14 A. That's right, yes.

15

16 Q. Although, what I understood was that there was work
17 going on in that area.

18 A. We don't understand, not just with children, with
19 adults too, that some people will just bounce back from
20 some horrific experience, and others will be crushed by it,
21 and then a whole spectrum in between. So, we don't always
22 understand. We know some of the factors that make for
23 resilience. So, if you're healthy and intelligent and able
24 and had a good, strong family upbringing and environment,
25 then you are going to be more hardy than if you've been
26 damaged and abused and neglected and not loved and all
27 those sorts of things. But, even so, there's still a kind
28 of innate hardiness or lack of hardiness that sometimes is
29 hard to account for.

30

31 Q. That work that is currently going on, is that going on
32 in the psychiatric field?

33 A. Yes.

34

35 Q. In any particular area that you can draw to our
36 attention?

37 A. Resilience is something that's being researched all
38 the time, and also looking for what are the correlates.
39 So, can we see what factors are important in determining
40 resilience, and can we do things to make children more
41 resilient. There are counselling programs now that
42 actually aim at promoting resilience. But there's some
43 sort of innate level of resilience that is hard to account
44 for, but you can give a child an environment that will
45 promote resilience, and you can also provide counselling
46 that will promote resilience.

47

1 THE CHAIR: Q. Professor, you may not be able to answer
2 this, and don't be embarrassed if you can't, but a
3 significant part of our obligation is to make
4 recommendations so that, so far as possible, children
5 aren't abused in the future. Have you got any thoughts as
6 to where we might look or suggestions as to what might be
7 an approach that institutions might take to minimise the
8 risk?

9 A. I think when children are in institutional care
10 there's a risk of abuse.

11

12 Q. So much is plain. What should we be saying to
13 institutions to try and minimise it?

14 A. First of all, they have to face up to the fact that it
15 happens in every institution. I think religious
16 institutions have suffered a little bit in the past from
17 feeling that, if we just put good people in charge then
18 nothing bad will happen. I think we need to think about -
19 the way we think about money, for example, is quite
20 different. I mean, we have massive security in banks, and
21 that's not because we think all the people who work in
22 banks are bad people, we just know that human nature being
23 what it is, we've got to keep the money secure. We don't
24 treat children with the same level of, you know, we've got
25 to keep them secure. We do have the assumption that we
26 just get all these nice, good people and put them in charge
27 and everything will be okay. Wouldn't dream of running a
28 bank like that. Just, let's find some good people and put
29 them in charge and not worry about security.

30

31 So you've got to realise that, you know, children are
32 vulnerable to abuse by caretakers, and in institutions
33 they're far more vulnerable, so they need to think about,
34 have an approach to screening people and keeping
35 transparency in the way the place operates and an
36 environment where children are free to complain, to be
37 listened to if they have any problems, and not to have
38 authoritarian systems where you shut up and do as you're
39 told or don't complain. Children need to have their voices
40 heard and have sympathetic people who will listen to them,
41 and we just have to keep that level of reality testing,
42 that adults are prone to abuse children in their care, so
43 we have to have scrutiny of these institutions.

44

45 COMMISSIONER MURRAY: Q. Professor, following from the
46 Chair's questions to you, the Royal Commission is
47 interested, and then there's examining the prospects for a

1 public health model with respect to prevention really of
2 child sexual abuse; you'd be familiar with the concept;
3 yes?

4 A. Yes.

5
6 Q. In what respects, do you think, a public health model
7 approach might facilitate much less abuse and a more secure
8 and more safe environment for children?

9 A. Well, I think it's absolutely essential that we have a
10 public health approach, because the biggest risk to
11 children is abuse and violence, and family violence and
12 abuse and trauma, and we have public health approaches to
13 all kinds of illnesses, but the biggest cause of morbidity
14 is right under our noses and we don't have a public health
15 approach to it.

16
17 Family violence and abuse and trauma are huge
18 morbidity factors; there's not a psychiatric diagnosis
19 that's not correlated in some way. 50 per cent of people
20 who are hospitalised with mental illness have a history of
21 childhood trauma. If 50 per cent of people who were
22 hospitalised had a history of drinking cow's milk, or
23 whatever, we'd ban it instantly, but we don't have that
24 public health model at all

25
26 The other problem is that, because there's not a
27 discrete syndrome, it cuts across all areas, that's also
28 been hard for people - people have these sort of discrete
29 areas, you know, there's this area and that area and the
30 other area - well, it cuts across all those areas.

31
32 And the transmission - I haven't mentioned
33 transmission - the transmission of trauma is extremely
34 significant. For example, 40 per cent of boys who grew up
35 in a domestic violence household are likely to become
36 domestic violence perpetrators themselves. Now, there are
37 not many genes that have 40 per cent penetration, and yet,
38 there's a massive amount of research money that goes into
39 looking at the gene that causes depression and the gene
40 that causes schizophrenia and the gene that causes ADHD,
41 and we've got causes under our noses that we're not doing
42 anything about, which is that if you brutalise children
43 when they're little, they're going to behave in bad ways
44 when they get bigger. But we're not doing enough.

45
46 Q. Professor, we have some ideas about what a public
47 health model might look like, but I'd be interested to know

1 from you what do you think the main constituent elements of
2 a public health model should be in the area of child sexual
3 abuse?

4 A. Understanding first of all that childhood abuse and
5 neglect and adversity is the single greatest pathogen that
6 children are exposed to, over and above all other
7 pathogenic influences in our community. If you put
8 together all the problems of childhood adversity, so then
9 you look at poverty, neglect, abuse, violence, all of that,
10 they are the biggest components, and they cost the
11 community a fortune. So, it's important that we deal with
12 it as the biggest pathogen.

13

14 It's not easy to deal with a pathogen that's so
15 widespread and that there's a huge amount of denial about,
16 but we've been able to do it in other areas and we can do
17 it in this area.

18

19 Q. A second area I wished to ask you about briefly: you
20 have given evidence about impact arising from child sexual
21 abuse. Would you explain to us what you feel are the
22 differences in impact between abuse by an adult or abuse by
23 an older child on the victim?

24 A. If there's a considerable age difference between the
25 victim and the perpetrator, then the fact that the offender
26 is not an adult doesn't make a great deal of difference.
27 We generally define abuse as being when there's more than
28 three years difference or where it's coercive or violent,
29 because there's sexual play that goes on between children
30 that's not abusive.

31

32 But, once a child has been abused by a child who's
33 three or more years older, then it pretty much fits into
34 the paradigm of abuse generally.

35

36 Q. So the impact would be similar?

37 A. It's similar, yes.

38

39 Q. The last area I just wanted to deal with briefly, if
40 you wouldn't mind: your evidence has concentrated, because
41 that's where the majority of offence lies, on men. Where
42 the offender is a female, an adult female with a child and
43 in an institutional context, are there differences that we
44 should note in terms of impact or causality or anything at
45 all?

46 A. Again, there's a huge amount of childhood trauma in
47 the background of women who offend. It's really very

1 unusual to find a female offender who hasn't got a history
2 of childhood trauma and abuse herself, and substance abuse
3 is really very common too amongst women - well, amongst all
4 offenders, but women offenders it's often substance abuse
5 as well. Otherwise - and it is unusual - it's not that
6 women don't abuse children, they do, but sexual abuse is
7 not much of a modus operandi with women. Women will abuse
8 children physically and psychologically and verbally, but
9 sexual abuse is not so common. But, where there is sexual
10 abuse, in my experience almost always it's a background of
11 the woman having been sexually abused herself.
12

13 Then there's a smaller group which is notable but
14 where they're working in conjunction with a male offender.
15 Occasionally, some of the famous cases but they're really
16 unusual, where they're working in conjunction with a male
17 offender.
18

19 Q. You have said it's very unusual. We have had evidence
20 at some public hearings, and of course we've also had
21 discussions with thousands of victims, where it has been
22 reported to us that women have known that offending by men
23 was going on. Is that in your experience a more common
24 matter?

25 A. Yes, I think women have been - women have sometimes
26 colluded in that way by not taking action, sometimes
27 because they're intimidated but sometimes because,
28 particularly in the church, there's that false view of the
29 good name of the church is really important and will do
30 more harm to the community by disclosing than by covering
31 up. So I think that women have been complicit in that, for
32 the variety of motivations, from being complicit to being
33 fearful, or fearful of retribution. And there have been
34 nuns who have been very physically abusive towards children
35 in their care. There are a lot of people I have seen who
36 have had very sadistic experiences with nuns and
37 occasionally sexual abuse as well by nuns.
38

39 MS FURNESS: Q. Doctor, you know that there are tens of
40 thousands of children in out-of-home care today.

41 A. (Witness nods).
42

43 Q. And you'll know that there's been a trend towards most
44 out-of-home care being provided in individual homes rather
45 than orphanages. Is there anything you can say to help the
46 Royal Commission understand what is a model for the
47 delivery of out-of-home care that is more protective of

1 children?

2 A. Well, there has to be scrupulous screening. I've seen
3 cases of children abused in out-of-home care where, with a
4 little bit of digging around, you find out that the
5 offender's actually had some previous problems, so I think
6 the screening has to be really scrupulous.

7

8 The whole idea, children in out-of-home care are very
9 vulnerable to abuse. We need to do a lot more about
10 dealing with family problems, and I think that - you know,
11 you have to ensure that a child's safe, you can't leave
12 them in a home where they're being abused, but I don't
13 think enough is done to try to repair families that are not
14 functioning well.

15

16 Q. So there should be more early intervention, where
17 there are problems before the child is removed?

18 A. Sometimes children are removed where I don't think
19 there's been nearly enough effort made to rehabilitate the
20 parents or the mother. Drug offenders are a real problem
21 because treating drug offenders is very hard work. But
22 removing the children and putting them in out-of-home care,
23 that's not a solution either, we need to be a bit cleverer
24 about this.

25

26 Q. In cases where it is in the interests of the child to
27 be removed from their family, what is it about out-of-home
28 care that can be more protective than it is now when you
29 understand that most children in out-of-home care are
30 living in individual families, leaving aside screening, I
31 understand what you're saying about screening.

32 A. There are lots of families who have provided
33 extraordinarily well for children placed in their care, but
34 still, there is a very significant incidence of abuse of
35 children in out-of-home care as well. So I think
36 prevention, we need to do more at the beginning before - we
37 don't have nearly enough people working in family and
38 community services. Everybody knows that the workers have
39 their work cut out, they can only deal with the worst.
40 There are a number of children every year who die of abuse
41 and neglect and trauma at home because they haven't got the
42 services. We're not treating children like the priceless
43 commodity that they really are.

44

45 Q. Is there a better model than having children in
46 individual homes?

47 A. We don't do nearly enough mother and infant care that

1 we could do. For example, a woman who's not functioning
2 well as a mother, the tendency is to remove the children,
3 even if it's supposed to be on a temporary basis, but
4 that's very damaging to a child anyway. We don't have
5 nearly enough mother and child treatment units. We could
6 put mothers into a treatment unit where they are resident
7 with their children and are treated while they are
8 resident. There's very little of that. There's not even a
9 lot of mother-infant units in New South Wales. You know,
10 infancy is a very critical time, we're not doing nearly
11 enough to deal with mother-infant problems.
12

13 We should be trying to get people to be better
14 parents, rather than waiting until the thing breaks down or
15 the children are abused.
16

17 Q. You would agree that the move from the orphanage-style
18 provision of out-of-home care to the current one is
19 preferable?

20 A. Well, institutional care is not good for children, no.
21 The sad thing is that children are abused by their own
22 biological parents, but the further you remove a child from
23 the biological parent, the more the incidences of abuse
24 goes up. Until, if you have complete strangers looking
25 after children, like in detention centres and so forth,
26 then the rate of abuse just goes higher and higher and
27 higher. Once that kind of bond of attachment is not there
28 between an adult and the child, the risk of abuse becomes
29 very significant.
30

31 Q. And if a child has been abused sexually in the
32 familial setting and then is removed and placed in another
33 family, as it were, what are the chances of that child
34 being abused in this placement?

35 A. As I said, the further away you go from your
36 biological parents, the more your risk of abuse increases,
37 just as a sort of a risk factor; that's not to say that
38 there aren't lots and lots of foster families and adoptive
39 families that are wonderful. But just looking at raw
40 statistics, the further you are removed, the more likely
41 you are to be abused.
42

43 Q. So more resources should be put into early
44 intervention in families that are struggling and more
45 resources should be put into alternative forms of
46 accommodation, such as, as you say, mother and infant
47 units?

1 A. We have very little in the way of mother-infant
2 services and parent-child services. We had a service in
3 Sydney that was an admission unit for children with their
4 families, and that's been wound down till it's - I think
5 the program is not even running any more, and there was
6 only one program in all of Sydney.

7
8 Q. There was a program, wasn't there, where the
9 Department of Health people visited new parents,
10 particularly mothers, over a period of time to see how they
11 were getting on?

12 A. Yes, but that's a study that hasn't been sufficiently
13 acted upon either; a lot of it was done by a particular
14 person called Olds who did a 15 year study of having home
15 visitors, usually nurses, and they just go to the home
16 where there's - it started in pregnancy, had a visit to the
17 mother; they picked vulnerable women, like young teen
18 single mums, and follow them over a 15 year period with a
19 regular home visit, and the delinquency rates dropped by
20 something like 90 per cent in the ones that had the regular
21 home visitor.

22
23 Q. Is that program across Australia or just in New South
24 Wales?

25 A. It's not across Australia, no.

26
27 Q. But it's still operating in New South Wales?

28 A. No, the Olds didn't work in New South Wales, this is
29 an American study. But there have been studies like that
30 that show very good outcomes when you institute some fairly
31 simple things; you know, this is having a regular adult who
32 visits and just as a kind of a troubleshooter and a
33 shoulder to cry on if things go wrong and that makes a huge
34 difference.

35
36 MS FURNESS: Thank you.

37
38 THE CHAIR: Now, does anyone else have any questions?
39 Anyone else at all? No. Very well.

40
41 **<EXAMINATION BY MR MOLONEY:**

42
43 MR MOLONEY: Q. I represent two men who gave evidence
44 last week and they reported and gave evidence which was all
45 too characteristic of the evidence given by the people who
46 have given evidence.

1 One of the things that my clients have discussed is
2 the possibility of a triage or a process at the
3 commencement of counselling whereby they are able to
4 essentially have an audit of their life as it is at that
5 point. The difficulty that they are experiencing is that
6 they are not necessarily the best advocate for their own
7 position. The developmental and psychological and memory
8 issues that you've very clearly identified render the
9 individual only able to self-report a component of what
10 they are experiencing, and there's a good much else which
11 they are not even aware of which could be ascertained by
12 psychometric testing, by psychiatric assessment, by
13 physical assessment and by interview with partners and
14 siblings and the like.

15
16 Is there merit in the proposition, particularly in
17 Ballarat where we have a large number of people all seeking
18 care and counselling, for a triage system of that type with
19 high quality, highly experienced people conducting the
20 triage, compiling reports, and then that report being used
21 as a basis for ongoing assessment?

22 A. So, that kind of prioritises the problems and the
23 needs?

24
25 Q. Yes.

26 A. Yes, I agree, yes. Especially when there's been - I
27 think there's been a lot of people in the Ballarat area who
28 have been affected.

29
30 Q. On a second and unrelated issue, you made reference to
31 various assessments that you've conducted. My clients are
32 very concerned about being able to identify or imagine the
33 life that they might have had but for the abuse and, as
34 they learn more and as people listen and educate themselves
35 in the way - of the consequences that you're
36 demonstrating - the notion of the harm ripples out and
37 expands exponentially.

38
39 So, in the process of imagining or for the purposes of
40 perhaps seeking compensation they try and imagine what
41 else, what might have been.

42
43 Is it possible for people in their 40s or their 50s to
44 disaggregate the normal vicissitudes of life or other
45 adverse child events from the specific sequelae to
46 childhood sexual abuse, or is that not something that a --
47 A. It's difficult, because if you're traumatised as a

1 child, it affects every part of your being, so every part
2 of your being is affected by that experience. It's not
3 like you can isolate it like, just one organ; not like
4 you've just got kidney damage but your liver is working
5 fine. It's like every part of your person is affected by
6 that, so it's really difficult to separate out. It's
7 almost impossible to know what could have been if it hadn't
8 been for the trauma because every part of your being has
9 been affected by it.

10
11 Q. Though it is difficult, can useful observations be
12 made from a psychiatric perspective?

13 A. Observations about what? What might have been?
14

15 Q. The what if.

16 A. The what if? You know, that question opens up a huge
17 amount of grief for the victim; it's really difficult to
18 deal with, because there's a huge amount of grief that goes
19 into just posing the question of what might have been; it's
20 a life lost, it's an identity shattered. It's very
21 difficult to deal with what might have been and it's
22 unknowable, unless - if you're in a family where you've got
23 siblings who were completely unaffected by the trauma, you
24 can sometimes look at your siblings and think, well,
25 roughly I should have - you know, if my brothers have all
26 gone to university or my sisters are all happily married
27 and have beautiful children, then maybe that's what I could
28 have expected that I could have had if I had a different
29 life, but it's only a rough estimate.
30

31 Q. Is there some scientific rigor in that analysis, for
32 instance, between siblings?

33 A. Roughly, you can say that children - siblings in a
34 family tend to have similar, similar trajectories, not
35 identical but similar. So, if you look at a family and one
36 child was abused and is grossly affected and the other
37 three all seem to be living fairly secure and stable lives
38 and they've got employment and they've got stable
39 relationships, then you can say, well, there's only one
40 reason why this one's so different from the others.
41

42 Q. On a third unrelated point: amongst the Ballarat
43 survivors group, which is an informal group which my two
44 clients are a part of, they have discussed amongst
45 themselves and colloquially they have never come across an
46 instance of someone identifying as having been the subject
47 of childhood sexual abuse and this not being the case; that

1 is to say that their experience is that people would never
2 lie about such a thing.

3

4 Is there a body of literature about false reportage,
5 and is it --

6 A. Yes, it's unusual.

7

8 Q. And it is unusual?

9 A. It's unusual. It's unusual not only for children but
10 for adults as well; it's unusual. So, yes, false
11 allegations - there has to be a fairly solid motivation for
12 someone who make a false allegation, and considering the
13 amount of trauma that a disclosure brings, and most people
14 realise that that's not an easy path to take, you have to
15 ask yourself, what's the motivation for making a false
16 allegation? Children don't have much motivation at all to
17 make false allegations; adults sometimes do, but even so
18 false allegations of sexual assaults in adults are not
19 common either.

20

21 MR MOLONEY: Thank you.

22

23 THE CHAIR: No one else? Ms Furness?

24

25 MS FURNESS: Nothing further, Your Honour.

26

27 THE CHAIR: Thank you, professor. Thank you for your
28 evidence, you are excused.

29

30 <THE WITNESS WITHDREW

31

32 MS FURNESS: Your Honour, I understand my friend has
33 something to say.

34

35 DR HANSCOMBE: If the Commission please. I represent
36 Timothy Green. An enquiry has been made as to whether
37 Mr Green, although he has been excused from the witness
38 box, would be willing to be recalled by the Commission and
39 cross-examined, and my instructions are that he would be
40 willing to do that.

41

42 THE CHAIR: Thank you. Ms Furness?

43

44 MS FURNESS: Thank you, Your Honour. There's no further
45 witnesses today. Father McInerney will be giving evidence
46 in the morning.

47

1 THE CHAIR: Mr Gray, is it proposed to ask that Mr Green
2 be available?
3
4 MR GRAY: No. I don't know what enquiry my learned friend
5 was referring to. It wasn't an enquiry from us.
6
7 THE CHAIR: Sorry?
8
9 MR GRAY: I don't know, is the answer to Your Honour's
10 question. I don't know what enquiry my learned friend is
11 referring to. It was not an enquiry from us.
12
13 THE CHAIR: I'm now totally confused. It's plain to us
14 that Mr Green is prepared to be cross-examined. I take it,
15 you're saying you don't want to cross-examine him?
16
17 MR GRAY: I am saying that.
18
19 THE CHAIR: Very well. Yes.
20
21 DR MARICH: And the position is the same in relation to
22 Mr David Ridsdale.
23
24 THE CHAIR: I'm sorry?
25
26 DR MARICH: The position is the same in relation to
27 Mr David Ridsdale.
28
29 THE CHAIR: Mr Ridsdale will make himself available to be
30 recalled to be cross-examined?
31
32 DR MARICH: If needed.
33
34 THE CHAIR: Well, Mr Gray?
35
36 MR GRAY: I hear that. I should say for the record that
37 both of those positions are very different from what was
38 conveyed to us on Friday, but in any event our position is
39 the same.
40
41 THE CHAIR: You don't wish Mr Ridsdale to be recalled
42 either?
43
44 MR GRAY: No.
45
46 THE CHAIR: Very well. Ms Furness?
47

1 MS FURNESS: Perhaps we could adjourn until 10am tomorrow
2 morning, Your Honour, if that's convenient.

3

4 THE CHAIR: 10am in the morning.

5

6 **AT 1.02PM THE COMMISSION WAS ADJOURNED**
7 **TO TUESDAY, 26 MAY 2015 AT 10AM**

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1
1.02PM [1] - 8497:6
10 [1] - 8473:2
10-20 [1] - 8463:47
10.00am [1] - 8441:26
10.20am [1] - 8442:19
100 [4] - 8441:21,
8469:36, 8469:38,
8470:26
10am [2] - 8497:1,
8497:4
10AM [1] - 8497:7
11 [6] - 8477:42,
8477:44, 8478:3,
8480:18, 8480:31,
8480:35
15 [2] - 8492:14,
8492:18
1940s [1] - 8444:3
1980s [3] - 8443:28,
8443:33, 8448:26
1985 [1] - 8442:43
1991 [2] - 8448:6,
8448:20
1998 [5] - 8447:44,
8448:3, 8448:4,
8448:7, 8448:15

2
20 [6] - 8449:1,
8452:17, 8456:3,
8462:2, 8469:38,
8473:2
20-40 [1] - 8456:13
200 [1] - 8443:23
2000s [1] - 8476:44
2001 [1] - 8476:45
2008 [4] - 8446:10,
8446:23, 8446:47,
8484:44
2010 [1] - 8447:5
2015 [1] - 8497:7
20s [1] - 8455:14
25 [2] - 8441:26,
8452:4
250 [2] - 8443:30,
8443:31
26 [1] - 8497:7
28 [1] - 8441:16

3
30 [2] - 8452:4,
8452:16
32 [4] - 8443:31,
8443:32, 8444:25,
8445:13

4
40 [3] - 8456:3,
8487:34, 8487:37
40s [2] - 8484:38,
8493:43

5
5 [1] - 8472:23
5-15 [1] - 8452:6
50 [3] - 8476:21,
8487:19, 8487:21
50s [2] - 8484:38,
8493:43

6
60 [2] - 8477:14,
8477:16

7
7 [2] - 8472:23,
8479:18
70 [1] - 8445:21

8
80 [2] - 8477:14,
8477:17
81 [1] - 8441:17

9
90 [1] - 8492:20

A
Abel [1] - 8454:17
ability [3] - 8449:28,
8449:29
able [18] - 8444:2,
8444:41, 8448:16,
8454:34, 8459:31,
8468:19, 8468:28,
8470:12, 8470:13,
8475:1, 8481:11,
8484:46, 8485:23,
8486:1, 8488:16,
8493:3, 8493:9,
8493:32
abnormality [1] -
8454:8
abreast [1] - 8470:29
absolutely [6] -
8470:14, 8470:38,
8471:26, 8478:38,
8482:8, 8487:9
ABUSE [1] - 8441:12
abuse [140] - 8443:6,
8443:7, 8443:12,
8443:13, 8443:17,

8443:18, 8443:28,
8444:15, 8444:16,
8444:17, 8444:20,
8444:28, 8444:30,
8444:31, 8444:37,
8445:17, 8445:31,
8445:33, 8445:34,
8445:40, 8446:8,
8446:11, 8446:42,
8447:17, 8447:46,
8448:11, 8448:25,
8448:28, 8448:29,
8448:33, 8449:7,
8449:10, 8449:32,
8449:42, 8449:43,
8449:46, 8450:3,
8450:5, 8450:7,
8450:10, 8450:12,
8450:21, 8450:23,
8450:26, 8450:27,
8451:17, 8451:25,
8451:29, 8451:40,
8452:5, 8452:10,
8452:26, 8452:41,
8453:15, 8456:20,
8456:35, 8456:42,
8457:17, 8457:21,
8457:34, 8458:12,
8458:39, 8460:26,
8461:19, 8461:23,
8461:27, 8462:32,
8463:7, 8464:6,
8464:7, 8464:10,
8464:37, 8465:2,
8465:13, 8465:19,
8465:25, 8466:9,
8467:17, 8470:42,
8470:44, 8470:45,
8471:4, 8471:37,
8471:40, 8472:31,
8472:47, 8474:2,
8474:15, 8474:17,
8477:13, 8477:20,
8477:25, 8478:39,
8480:47, 8482:32,
8482:45, 8482:46,
8484:12, 8484:13,
8484:14, 8484:17,
8486:10, 8486:32,
8486:42, 8487:2,
8487:7, 8487:11,
8487:12, 8487:17,
8488:3, 8488:4,
8488:9, 8488:21,
8488:22, 8488:27,
8488:34, 8489:2,
8489:4, 8489:6,
8489:7, 8489:9,
8489:10, 8489:37,
8490:9, 8490:34,
8490:40, 8491:23,

8491:26, 8491:28,
8491:36, 8493:33,
8493:46, 8494:47
Abuse [1] - 8447:6
abuse" [1] - 8449:40
abused [55] - 8443:24,
8447:15, 8449:20,
8449:25, 8450:20,
8451:8, 8451:31,
8451:36, 8451:43,
8452:30, 8456:4,
8457:20, 8458:45,
8461:47, 8462:30,
8463:11, 8463:16,
8463:40, 8463:46,
8464:28, 8465:39,
8466:12, 8466:31,
8466:34, 8466:47,
8467:2, 8467:13,
8467:14, 8467:21,
8468:1, 8468:31,
8468:34, 8470:33,
8470:36, 8471:24,
8472:22, 8472:39,
8472:41, 8473:24,
8477:10, 8478:19,
8480:13, 8481:47,
8485:26, 8486:5,
8488:32, 8489:11,
8490:3, 8490:12,
8491:15, 8491:21,
8491:31, 8491:34,
8491:41, 8494:36
abuser [3] - 8451:3,
8462:24, 8473:31
abusers [2] - 8449:36,
8465:7
abuses [2] - 8462:24,
8482:47
abusing [4] - 8450:8,
8461:21, 8465:2,
8474:10
abusive [11] - 8444:8,
8444:38, 8445:39,
8450:6, 8450:46,
8451:21, 8451:34,
8468:32, 8488:30,
8489:34
accept [7] - 8469:17,
8470:35, 8476:2,
8476:3, 8476:25,
8478:32, 8483:34
accepted [4] -
8459:30, 8474:17,
8474:23, 8484:31
access [6] - 8453:23,
8453:24, 8461:22,
8473:35, 8473:38,
8474:30
accident [1] - 8461:12

accommodation [1] -
8491:46
account [3] - 8468:23,
8485:29, 8485:43
accounts [1] - 8460:4
accreditation [3] -
8469:19, 8469:28,
8481:23
accrediting [1] -
8469:18
accumulated [1] -
8448:46
accusations [1] -
8478:42
acquainted [1] -
8460:46
act [1] - 8468:2
acted [1] - 8492:13
acting [4] - 8457:4,
8457:14, 8457:15,
8477:34
action [1] - 8489:26
activity [1] - 8466:8
actual [2] - 8450:12,
8451:39
adaptive [1] - 8476:8
addition [2] - 8481:10,
8482:17
address [1] - 8447:5
addressing [1] -
8455:17
adds [1] - 8473:2
adept [1] - 8473:38
adequate [4] -
8467:41, 8475:1,
8478:1, 8478:2
ADHD [3] - 8480:26,
8480:41, 8487:40
adjourn [2] - 8471:32,
8497:1
ADJOURNED [1] -
8497:6
adjournment [1] -
8471:31
ADJOURNMENT [1] -
8471:34
adjusted [1] - 8453:36
adjustment [4] -
8454:45, 8454:46,
8459:4, 8465:38
administration [1] -
8482:7
admire [1] - 8484:1
admission [1] -
8492:3
admit [3] - 8475:22,
8475:33, 8476:20
adolescent [6] -
8442:36, 8455:9,
8455:18, 8455:20,

8463:11, 8466:8
Adolescent [1] -
8447:45
adolescents [4] -
8463:16, 8467:12,
8467:15, 8482:46
adoptive [1] - 8491:38
adult [13] - 8454:21,
8458:12, 8459:46,
8460:25, 8463:21,
8474:2, 8475:2,
8488:22, 8488:26,
8488:42, 8491:28,
8492:31
adult's [1] - 8471:38
adults [14] - 8443:3,
8447:15, 8447:26,
8453:21, 8457:40,
8458:13, 8458:14,
8459:43, 8463:18,
8485:19, 8486:42,
8495:10, 8495:17,
8495:18
advantage [1] -
8474:39
adverse [1] - 8493:45
adversity [2] - 8488:5,
8488:8
advice [1] - 8481:36
advocate [1] - 8493:6
affect [6] - 8458:5,
8458:6, 8462:38,
8463:30, 8467:23,
8479:35
affected [14] -
8449:27, 8459:9,
8461:29, 8462:41,
8462:43, 8462:45,
8463:31, 8465:35,
8465:36, 8493:28,
8494:2, 8494:5,
8494:9, 8494:36
affectionate [1] -
8462:17
affects [4] - 8449:20,
8449:26, 8461:31,
8494:1
affiliated [1] - 8472:9
afraid [5] - 8448:21,
8464:20, 8467:8,
8468:32
afterwards [1] -
8446:22
age [6] - 8453:29,
8455:8, 8455:34,
8455:40, 8457:24,
8488:24
ages [3] - 8448:21,
8448:32, 8472:23
aggressive [3] -
8456:46, 8457:14,
8457:15
ago [2] - 8462:2,
8465:11
agree [2] - 8491:17,
8493:26
aim [1] - 8485:42
air [1] - 8442:4
alcohol [5] - 8449:31,
8465:20, 8471:6,
8471:7, 8474:16
alcoholism [1] -
8444:41
alert [1] - 8465:28
alienated [1] -
8472:35
alienation [1] -
8472:34
allegation [2] -
8495:12, 8495:16
allegations [3] -
8495:11, 8495:17,
8495:18
allergy [2] - 8481:16,
8481:17
alleviate [1] - 8467:35
allow [1] - 8446:42
allowed [2] - 8459:31,
8460:36
allows [1] - 8447:17
almost [5] - 8457:21,
8460:4, 8465:13,
8489:10, 8494:7
alone [1] - 8481:31
alternative [1] -
8491:45
AM [1] - 8441:32
America [3] - 8446:20,
8448:7, 8454:17
American [1] -
8492:29
amnesia [1] - 8459:10
amount [17] - 8448:8,
8452:2, 8454:18,
8458:8, 8469:34,
8477:47, 8478:30,
8481:14, 8482:38,
8483:25, 8484:11,
8487:38, 8488:15,
8488:46, 8494:17,
8494:18, 8495:13
analysis [1] - 8494:31
Andrew [1] - 8441:35
Anglican [1] - 8446:16
angry [5] - 8456:45,
8466:10, 8466:11,
8477:38, 8480:35
animals [1] - 8465:5
Ann [1] - 8441:34
annual [1] - 8447:44
answer [2] - 8486:1,
8496:9
anxiety [5] - 8458:16,
8463:43, 8465:18,
8465:26, 8467:1
anxious [2] - 8449:30,
8477:44
anyway [4] - 8471:7,
8471:10, 8478:44,
8491:4
application [1] -
8454:6
applies [1] - 8472:16
apply [1] - 8473:32
approach [12] -
8449:13, 8449:14,
8449:18, 8453:10,
8458:31, 8468:7,
8480:37, 8486:7,
8486:34, 8487:7,
8487:10, 8487:15
approached [4] -
8446:23, 8482:31,
8485:4, 8485:5
approaches [4] -
8468:21, 8482:22,
8482:29, 8487:12
area [26] - 8443:10,
8446:47, 8448:20,
8449:22, 8454:12,
8455:45, 8457:4,
8461:3, 8461:9,
8468:15, 8469:2,
8469:24, 8478:29,
8478:37, 8478:42,
8479:25, 8485:17,
8485:35, 8487:29,
8487:30, 8488:2,
8488:17, 8488:19,
8488:39, 8493:27
areas [10] - 8445:24,
8449:24, 8454:32,
8473:35, 8473:37,
8480:13, 8487:27,
8487:29, 8487:30,
8488:16
argument's [1] -
8472:22
arise [1] - 8466:38
arisen [1] - 8474:39
arises [1] - 8464:28
arising [1] - 8488:20
army [1] - 8477:11
arrived [1] - 8457:10
ascertained [1] -
8493:11
ashamed [3] -
8471:11, 8471:12,
8480:22
aside [1] - 8490:30
aspect [6] - 8449:21,
8460:4, 8461:34,
8464:13, 8471:39,
8471:40
assault [1] - 8458:35
assaults [1] - 8495:18
assess [4] - 8443:31,
8482:31, 8483:1
assessed [2] -
8443:32, 8445:12
assessing [1] -
8443:28
assessment [5] -
8445:10, 8483:4,
8493:12, 8493:13,
8493:21
assessments [3] -
8482:19, 8482:44,
8493:31
assist [1] - 8448:16
assistance [1] -
8453:37
assisted [1] - 8448:15
Assisting [1] -
8441:39
Associate [1] -
8442:25
assume [2] - 8465:41,
8470:35
assuming [1] -
8448:23
assumption [1] -
8486:25
asthma [1] - 8463:44
asymptomatic [2] -
8456:13, 8472:15
AT [2] - 8497:6,
8497:7
attached [3] -
8464:31, 8465:1,
8465:7
attaches [1] - 8465:12
attachment [3] -
8464:26, 8464:29,
8491:27
attempts [1] - 8482:1
attention [5] - 8448:9,
8448:22, 8451:12,
8474:21, 8485:36
attention's [1] -
8458:4
attentive [1] - 8458:4
attitudes [1] - 8448:36
attracted [8] -
8453:17, 8453:34,
8453:38, 8454:16,
8455:33, 8473:34,
8473:37, 8473:47
audit [1] - 8493:4
Australia [6] - 8444:9,
8448:4, 8452:43,
8460:28, 8492:23,
8492:25
Australian [3] -
8442:34, 8445:41,
8452:33
Austria [1] - 8452:44
authoritarian [1] -
8486:38
authority [5] -
8453:24, 8453:25,
8473:13, 8484:20,
8484:32
autoimmune [1] -
8463:45
available [3] - 8449:2,
8496:2, 8496:29
avoid [1] - 8468:26
avoidance [2] -
8458:31, 8458:33
avoidant [1] - 8458:37
avoiding [1] - 8459:3
aware [9] - 8452:32,
8454:12, 8457:30,
8460:36, 8467:15,
8480:46, 8481:1,
8483:47, 8493:11
awareness [2] -
8481:14, 8483:31
awful [2] - 8477:8,
8481:17

B

baby [1] - 8457:10
background [2] -
8488:47, 8489:10
backgrounds [1] -
8477:13
bad [25] - 8450:39,
8459:42, 8460:22,
8460:25, 8460:28,
8463:5, 8464:21,
8465:24, 8466:41,
8471:28, 8471:44,
8471:45, 8472:3,
8472:11, 8475:29,
8477:43, 8478:9,
8478:10, 8478:44,
8480:40, 8486:18,
8486:22, 8487:43
bad" [1] - 8459:43
badly [3] - 8445:29,
8460:21, 8460:22
Ballarat [5] - 8441:20,
8441:21, 8493:17,
8493:27, 8494:42
ban [1] - 8487:23
bank [1] - 8486:28
banks [2] - 8486:20,

8486:22
banned [1] - 8480:20
barrier [1] - 8483:25
barriers [1] - 8483:21
based [5] - 8451:27,
8452:19, 8454:14,
8467:26, 8477:16
basis [3] - 8459:22,
8491:3, 8493:21
bastards [2] - 8444:33
battery [1] - 8462:8
bear [1] - 8458:34
beautiful [1] - 8494:27
became [4] - 8443:27,
8443:29, 8455:10,
8478:42
become [23] -
8452:27, 8455:27,
8455:39, 8456:8,
8457:30, 8457:31,
8460:36, 8464:47,
8465:44, 8465:47,
8466:5, 8466:8,
8466:15, 8466:47,
8467:11, 8467:13,
8467:16, 8477:31,
8477:33, 8477:34,
8484:7, 8487:35
becomes [9] -
8449:33, 8452:26,
8455:20, 8457:18,
8460:33, 8461:34,
8478:47, 8484:8,
8491:28
becoming [3] -
8448:19, 8448:42,
8455:11
bed [1] - 8456:45
befriend [1] - 8473:24
begin [2] - 8460:21,
8460:35
beginning [2] -
8448:15, 8490:36
behave [1] - 8487:43
behaviour [6] -
8456:45, 8457:18,
8457:20, 8467:40,
8476:7, 8481:11
behaviours [1] -
8457:25
behind [2] - 8466:39,
8479:33
beings [3] - 8456:24,
8465:6, 8468:3
belief [2] - 8471:46,
8472:20
believers [1] - 8484:2
benefit [4] - 8455:16,
8455:23, 8455:25,
8466:40

best [5] - 8469:5,
8470:5, 8476:40,
8476:41, 8493:6
betrayal [2] - 8450:37,
8471:43
betrayed [2] -
8451:42, 8466:10
better [4] - 8469:4,
8480:46, 8490:45,
8491:13
between [12] - 8444:9,
8450:27, 8461:8,
8470:44, 8470:45,
8472:23, 8485:21,
8488:22, 8488:24,
8488:29, 8491:28,
8494:32
big [5] - 8443:35,
8448:27, 8480:35,
8482:40
bigger [1] - 8487:44
biggest [4] - 8487:10,
8487:13, 8488:10,
8488:12
bill [1] - 8482:3
Bindoo [2] -
8444:14, 8444:23
binge [1] - 8471:9
biological [3] -
8491:22, 8491:23,
8491:36
bit [7] - 8463:32,
8474:33, 8479:23,
8482:12, 8486:16,
8490:4, 8490:23
biting [1] - 8480:21
blame [5] - 8459:41,
8460:20, 8471:26,
8475:38, 8483:41
blaming [1] - 8476:3
blanking [1] - 8458:29
blanks [1] - 8478:27
board [2] - 8448:29,
8461:4
boarding [1] - 8445:25
boat [1] - 8480:38
bodies [5] - 8469:17,
8469:23, 8469:33,
8469:45, 8470:7
body [2] - 8449:1,
8495:4
bogeyman [1] -
8464:21
bond [3] - 8464:29,
8464:32, 8491:27
born [1] - 8457:8
Boston [2] - 8448:8,
8448:9
bother [2] - 8453:19,
8453:20

bottled [3] - 8479:45,
8479:46, 8479:47
bounce [1] - 8485:19
box [3] - 8454:5,
8454:7, 8495:38
boy [3] - 8453:28,
8478:10, 8479:19
boy's [2] - 8477:32,
8477:41
boys [14] - 8444:18,
8444:24, 8445:18,
8445:22, 8445:36,
8452:6, 8452:17,
8455:9, 8465:39,
8477:30, 8477:37,
8479:4, 8480:34,
8487:34
brain [18] - 8461:46,
8462:14, 8462:20,
8462:29, 8462:30,
8462:35, 8462:38,
8462:44, 8462:45,
8463:3, 8463:16,
8463:22, 8463:27,
8463:29, 8463:30,
8463:37, 8464:5,
8478:16
brains [4] - 8462:8,
8462:11, 8462:19,
8462:37
break [2] - 8471:32,
8472:37
breaking [2] -
8474:21, 8474:22
breaks [1] - 8491:14
brief [1] - 8466:37
briefly [2] - 8488:19,
8488:39
bringing [1] - 8444:10
brings [3] - 8460:37,
8482:44, 8495:13
Britain [3] - 8443:41,
8444:10
Brothers [8] -
8443:29, 8443:40,
8444:32, 8448:5,
8448:19, 8450:1,
8452:25, 8484:37
brothers [1] - 8494:25
brutal [1] - 8444:21
brutalise [1] - 8487:42
buried [2] - 8479:26,
8479:39
burned [1] - 8478:25
bursting [1] - 8464:19
BY [2] - 8442:21,
8492:41

C

calamity [1] - 8466:26
capacity [1] - 8449:27
captive [2] - 8464:36,
8473:11
car [1] - 8461:12
care [29] - 8444:2,
8451:28, 8451:36,
8451:37, 8452:7,
8452:15, 8452:17,
8464:46, 8465:14,
8469:5, 8484:18,
8484:28, 8486:9,
8486:42, 8489:35,
8489:40, 8489:44,
8489:47, 8490:3,
8490:8, 8490:22,
8490:28, 8490:29,
8490:33, 8490:35,
8490:47, 8491:18,
8491:20, 8493:18
careful [3] - 8466:35,
8473:15, 8473:16
carefully [2] -
8479:12, 8479:16
carer [1] - 8461:21
carers [1] - 8460:26
caretakers [3] -
8443:25, 8451:29,
8486:32
CAROLYN [1] -
8442:19
Carolyn [1] - 8442:25
Case [1] - 8441:16
case [14] - 8443:29,
8443:30, 8443:33,
8445:32, 8448:5,
8448:8, 8448:9,
8450:4, 8475:40,
8478:47, 8479:9,
8484:1, 8484:18,
8494:47
cases [6] - 8448:7,
8448:19, 8450:2,
8489:15, 8490:3,
8490:26
category [1] - 8475:25
Catholic [8] - 8446:15,
8452:35, 8452:42,
8452:47, 8454:43,
8455:8, 8474:4,
8474:11
causality [1] - 8488:44
caused [3] - 8444:47,
8452:34, 8460:14
causes [4] - 8487:39,
8487:40, 8487:41
celibacy [7] - 8453:4,
8453:5, 8453:13,

8453:14, 8453:19,
8453:31, 8454:43
cent [15] - 8452:4,
8452:6, 8452:16,
8452:17, 8456:3,
8456:13, 8476:21,
8477:14, 8477:17,
8478:3, 8487:19,
8487:21, 8487:34,
8487:37, 8492:20
centres [1] - 8491:25
certain [2] - 8456:16,
8469:34
certainly [4] -
8455:39, 8476:23,
8479:28, 8483:32
certificate [1] - 8470:3
certify [1] - 8470:1
CHAIR [26] - 8442:1,
8442:6, 8449:40,
8455:6, 8456:19,
8462:22, 8464:3,
8469:16, 8470:20,
8470:31, 8471:31,
8486:1, 8492:38,
8495:23, 8495:27,
8495:42, 8496:1,
8496:7, 8496:13,
8496:19, 8496:24,
8496:29, 8496:34,
8496:41, 8496:46,
8497:4
Chair's [1] - 8486:46
chances [1] - 8491:33
change [6] - 8448:40,
8463:10, 8464:5,
8475:42, 8475:44,
8481:42
changed [1] - 8476:47
changes [15] -
8461:45, 8461:46,
8462:30, 8462:35,
8462:37, 8462:38,
8462:42, 8462:45,
8463:1, 8463:16,
8463:22, 8463:37,
8463:38, 8463:39,
8464:3
changing [2] -
8448:36, 8476:7
channelled [2] -
8478:1, 8481:19
character [1] -
8465:36
characteristic [1] -
8492:45
characteristics [3] -
8473:9, 8473:31,
8474:43
characterological [3]

- 8461:33, 8465:36, 8472:4

charge [3] - 8486:17, 8486:26, 8486:29

CHILD [1] - 8441:12

Child [1] - 8447:45

child [98] - 8442:27, 8442:36, 8443:42, 8448:27, 8448:29, 8448:33, 8449:10, 8449:43, 8450:7, 8450:38, 8450:41, 8451:10, 8451:17, 8451:34, 8451:41, 8453:15, 8456:21, 8456:37, 8456:42, 8457:2, 8457:7, 8457:15, 8457:18, 8457:20, 8457:34, 8457:42, 8457:47, 8458:9, 8458:12, 8458:45, 8459:42, 8460:12, 8460:18, 8460:31, 8460:33, 8461:18, 8461:22, 8461:23, 8461:25, 8461:38, 8462:15, 8462:19, 8462:22, 8462:31, 8463:2, 8464:6, 8464:16, 8464:32, 8464:43, 8465:34, 8466:6, 8466:33, 8466:39, 8466:41, 8471:37, 8471:47, 8472:2, 8472:15, 8472:22, 8473:3, 8473:17, 8474:47, 8476:24, 8477:12, 8477:20, 8479:36, 8481:5, 8481:6, 8481:18, 8483:27, 8483:28, 8483:39, 8483:47, 8484:3, 8484:21, 8485:11, 8485:44, 8487:2, 8488:2, 8488:20, 8488:23, 8488:32, 8488:42, 8490:17, 8490:26, 8491:4, 8491:5, 8491:22, 8491:28, 8491:31, 8491:33, 8492:2, 8493:45, 8494:1, 8494:36

child's [15] - 8450:34, 8450:47, 8451:14, 8451:22, 8451:44, 8457:10, 8460:23, 8461:34, 8461:41, 8462:34, 8463:3, 8472:8, 8480:23, 8484:19, 8490:11

childhood [11] - 8443:24, 8449:20, 8465:13, 8478:6, 8487:21, 8488:4, 8488:8, 8488:46, 8489:2, 8493:46, 8494:47

childhoods [1] - 8477:25

children [152] - 8443:3, 8444:1, 8444:5, 8444:6, 8444:10, 8444:12, 8444:34, 8444:44, 8444:45, 8444:46, 8445:29, 8447:15, 8447:16, 8447:27, 8447:47, 8449:26, 8449:46, 8450:2, 8451:2, 8451:8, 8451:25, 8451:28, 8451:32, 8452:5, 8452:30, 8452:33, 8453:17, 8453:23, 8454:16, 8454:22, 8455:31, 8455:34, 8455:47, 8456:3, 8456:6, 8456:8, 8457:19, 8457:26, 8457:27, 8457:28, 8457:29, 8457:35, 8457:37, 8457:39, 8459:40, 8460:10, 8460:19, 8460:21, 8460:35, 8461:19, 8461:47, 8462:3, 8462:30, 8463:6, 8463:40, 8463:41, 8463:46, 8464:28, 8464:35, 8466:47, 8467:7, 8467:20, 8471:41, 8472:10, 8472:39, 8472:41, 8472:42, 8473:10, 8473:24, 8473:33, 8473:35, 8473:37, 8473:38, 8474:1, 8474:2, 8474:10, 8474:13, 8474:35, 8474:37, 8474:40, 8475:42, 8477:10, 8478:19, 8480:4, 8480:13, 8480:16, 8480:21, 8480:45, 8481:2, 8481:5, 8481:11, 8481:14, 8482:45, 8482:46, 8483:21, 8483:23, 8483:30, 8483:31, 8483:37, 8484:13, 8484:18, 8484:29, 8484:30, 8484:31, 8484:35, 8484:40, 8485:18, 8485:40, 8486:4, 8486:9, 8486:24, 8486:31, 8486:36, 8486:39, 8486:42, 8487:8, 8487:11, 8487:42, 8488:6, 8488:29, 8489:6, 8489:8, 8489:34, 8489:40, 8490:1, 8490:3, 8490:8, 8490:18, 8490:22, 8490:29, 8490:33, 8490:35, 8490:40, 8490:42, 8490:45, 8491:2, 8491:7, 8491:15, 8491:20, 8491:21, 8491:25, 8492:3, 8494:27, 8494:33, 8495:9, 8495:16

Christian [7] - 8443:29, 8443:40, 8448:5, 8448:19, 8450:1, 8452:25, 8484:37

chronic [1] - 8461:9

chronically [1] - 8471:5

Church [6] - 8446:15, 8446:16, 8452:35, 8452:42, 8454:43, 8455:8

church [9] - 8445:6, 8454:31, 8455:16, 8455:29, 8475:37, 8484:2, 8484:3, 8489:28, 8489:29

church" [1] - 8446:14

churches [3] - 8446:15, 8446:24, 8455:7

circumstances [2] - 8456:16, 8464:42

claimed [1] - 8478:38

classic [8] - 8457:36, 8458:13, 8458:20, 8458:21, 8459:2, 8459:17, 8461:10, 8461:16

clear [2] - 8457:39, 8461:46

clearly [1] - 8493:8

clergy [8] - 8443:25, 8446:8, 8447:47, 8448:34, 8471:37, 8471:42, 8473:24

Clergy [1] - 8447:6

cleverer [1] - 8490:23

clients [3] - 8493:1, 8493:31, 8494:44

cling [1] - 8464:44

clings [1] - 8465:5

clingy [1] - 8464:47

clinical [7] - 8443:15, 8443:19, 8447:25, 8467:26, 8478:17, 8481:44, 8482:17

clinically [1] - 8454:41

Clontarf [1] - 8444:24

close [3] - 8445:25, 8464:29, 8471:42

cluey [1] - 8481:34

coaches [1] - 8451:8

Coate [1] - 8441:34

COATE [1] - 8483:18

coercion [1] - 8456:35

coercive [1] - 8488:28

coexist [1] - 8458:32

cognitive [1] - 8462:18

colitis [1] - 8463:44

College [2] - 8442:34, 8447:46

colloquially [1] - 8494:45

colluded [1] - 8489:26

combination [4] - 8458:40, 8459:9, 8459:14, 8478:22

comfort [1] - 8481:30

comfortable [3] - 8453:18, 8453:21, 8466:1

coming [3] - 8443:44, 8459:12, 8464:21

commenced [1] - 8455:9

commencement [1] - 8493:3

Commission [8] - 8442:23, 8442:31, 8460:40, 8469:1, 8486:46, 8489:46, 8495:35, 8495:38

COMMISSION [2] - 8441:11, 8497:6

COMMISSIONER [3] - 8460:1, 8468:38, 8486:45

Commissioner [1] - 8441:34

Commissioners [1] - 8460:2

commit [2] - 8476:26, 8476:38

committed [2] - 8476:18, 8484:3

committing [1] - 8470:37

commodity [1] - 8490:43

common [14] - 8451:28, 8463:46, 8465:5, 8465:17, 8465:27, 8465:33, 8471:5, 8473:8, 8479:29, 8480:16, 8489:3, 8489:9, 8489:23, 8495:19

commonest [4] - 8458:15, 8465:18, 8465:26

community [24] - 8448:23, 8448:36, 8451:6, 8452:8, 8469:43, 8470:31, 8472:8, 8472:12, 8473:13, 8473:18, 8473:20, 8473:39, 8474:4, 8474:8, 8478:13, 8478:43, 8480:16, 8481:1, 8481:12, 8484:34, 8488:7, 8488:11, 8489:30, 8490:38

community's [1] - 8478:46

companies [1] - 8482:13

compare [1] - 8445:29

compensation [1] - 8493:40

compiling [1] - 8493:20

complain [2] - 8486:36, 8486:39

complaining [1] - 8445:8

complaints [1] - 8463:41

complete [2] - 8476:33, 8491:24

completely [3] - 8479:45, 8484:42, 8494:23

complex [4] - 8454:25, 8461:9, 8461:30, 8477:10

complicated [4] - 8462:18, 8473:15, 8477:29, 8479:23

complicit [2] - 8489:31, 8489:32

complying [1] - 8484:32

component [3] -

8450:24, 8483:9, 8493:9
components [1] - 8488:10
compound [1] - 8472:13
compounds [3] - 8447:22, 8471:13, 8480:22
compromises [1] - 8482:27
compulsory [1] - 8469:36
conceal [1] - 8457:27
concentrated [1] - 8488:40
concentrating [1] - 8458:2
concentration [1] - 8461:36
concept [1] - 8487:2
concern [2] - 8457:5, 8457:16
concerned [8] - 8449:35, 8450:29, 8455:17, 8457:17, 8462:39, 8471:23, 8483:28, 8493:32
concerns [1] - 8470:32
conditioning [1] - 8442:4
conduct [1] - 8475:1
conducted [1] - 8493:31
conducting [1] - 8493:19
conference [6] - 8446:10, 8446:21, 8446:27, 8446:39, 8447:44, 8484:44
Conference [1] - 8447:6
confined [1] - 8450:5
confused [3] - 8465:40, 8465:44, 8496:13
confusing [2] - 8464:33, 8468:4
Conjoint [1] - 8442:25
conjunction [3] - 8484:13, 8489:14, 8489:16
connection [1] - 8444:28
connects [1] - 8462:44
consciousness [1] - 8484:34
consensus [1] - 8452:45
consequence [1] - 8456:32
consequences [4] - 8445:38, 8466:43, 8471:3, 8493:35
consider [4] - 8451:17, 8451:47, 8460:45, 8482:34
considerable [4] - 8473:46, 8483:25, 8484:11, 8488:24
considered [1] - 8470:34
considering [1] - 8495:12
consistent [2] - 8452:6, 8467:30
consists [1] - 8458:21
constantly [1] - 8463:32
constituent [1] - 8488:1
consultant [1] - 8442:27
contact [9] - 8450:13, 8450:17, 8451:16, 8456:31, 8460:2, 8464:45, 8474:35, 8474:38, 8482:44
contaminated [1] - 8467:3
context [6] - 8455:22, 8471:40, 8474:11, 8478:45, 8482:42, 8488:43
contexts [3] - 8451:1, 8451:26, 8475:20
continually [1] - 8457:47
continue [2] - 8446:42, 8447:17
continues [1] - 8461:27
continuing [8] - 8469:24, 8469:34, 8469:35, 8469:37, 8469:47, 8470:1, 8470:6, 8470:23
continuum [1] - 8484:15
contradictory [3] - 8458:26, 8458:31, 8458:32
contrast [2] - 8445:18, 8466:4
contrition [2] - 8475:23, 8475:34
control [6] - 8451:3, 8453:6, 8453:7, 8467:41, 8468:11, 8484:20
controlling [1] - 8453:6
controversial [2] - 8478:37, 8479:25
controversy [2] - 8478:29, 8478:30
convene [1] - 8446:10
convenient [1] - 8497:2
conventional [1] - 8453:36
conversation [1] - 8458:36
conveyed [1] - 8496:38
convicted [1] - 8476:22
convictions [3] - 8448:33, 8448:39, 8448:41
cordials [1] - 8480:42
corporal [3] - 8484:30, 8484:34, 8484:38
correct [2] - 8483:30, 8483:31
correlated [1] - 8487:19
correlates [1] - 8485:38
cost [1] - 8488:10
counsel [2] - 8466:36, 8468:43
Counsel [1] - 8441:39
counselled [1] - 8483:4
counselling [22] - 8460:41, 8467:37, 8468:7, 8468:14, 8468:17, 8468:21, 8468:22, 8468:35, 8468:41, 8468:45, 8469:2, 8476:30, 8478:39, 8478:45, 8480:10, 8481:21, 8481:25, 8482:10, 8485:41, 8485:45, 8493:3, 8493:18
counsellors [1] - 8481:13
count [1] - 8479:1
counted [1] - 8452:3
countries [2] - 8452:22, 8452:43
country [3] - 8444:28, 8446:29, 8452:23
couple [3] - 8483:19, 8484:29, 8484:33
course [5] - 8466:23, 8478:42, 8478:45, 8484:42, 8489:20
court [1] - 8445:13
Court [1] - 8441:20
courts [2] - 8443:30, 8482:19
cover [2] - 8453:25, 8457:31
covered [1] - 8481:18
covering [1] - 8489:30
cow's [1] - 8487:22
creates [1] - 8465:6
creatures [3] - 8481:3, 8481:4, 8481:5
crime [1] - 8460:5
crimes [1] - 8468:40
critical [2] - 8447:20, 8491:10
cross [4] - 8495:39, 8496:14, 8496:15, 8496:30
cross-examine [1] - 8496:15
cross-examined [3] - 8495:39, 8496:14, 8496:30
crushed [1] - 8485:20
cry [1] - 8492:33
cuddled [1] - 8462:16
cuddling [1] - 8462:5
culpable [1] - 8460:18
culture [3] - 8465:19, 8465:20, 8465:23
cure [1] - 8449:16
current [2] - 8475:15, 8491:18
cut [4] - 8447:29, 8459:25, 8490:39
cuts [2] - 8487:27, 8487:30

D

dad [2] - 8484:2, 8484:5
damage [8] - 8451:40, 8463:33, 8464:43, 8472:4, 8472:13, 8472:44, 8494:4
damaged [9] - 8444:26, 8444:39, 8445:28, 8445:30, 8459:41, 8459:45, 8461:42, 8471:11, 8485:26
damaging [20] - 8445:32, 8447:21, 8448:29, 8450:24, 8450:35, 8450:37, 8450:41, 8451:40, 8451:41, 8451:44, 8456:36, 8457:42, 8458:1, 8459:40, 8461:38, 8461:43, 8471:46, 8472:27, 8472:34, 8491:4
dark [4] - 8448:21, 8448:23, 8448:32, 8464:20
date [2] - 8453:45, 8470:2
David [2] - 8496:22, 8496:27
days [1] - 8484:37
deal [13] - 8458:17, 8469:44, 8477:10, 8479:7, 8480:38, 8488:11, 8488:14, 8488:26, 8488:39, 8490:39, 8491:11, 8494:18, 8494:21
dealing [9] - 8461:31, 8461:33, 8465:9, 8465:21, 8465:29, 8466:1, 8471:12, 8478:43, 8490:10
death [1] - 8461:13
decades [2] - 8484:29, 8484:33
decide [1] - 8479:5
decompensate [1] - 8456:17
deep [1] - 8460:35
defiled [1] - 8459:41
defilement [1] - 8460:20
define [1] - 8488:27
definition [3] - 8450:44, 8451:17, 8478:32
degree [1] - 8453:5
delay [1] - 8472:19
delayed [2] - 8455:13, 8455:28
deliberately [1] - 8479:26
delinquency [2] - 8477:43, 8492:19
deliver [1] - 8477:7
delivery [1] - 8489:47
demonstrating [1] - 8493:36
denial [2] - 8475:38, 8488:15
denigrated [1] - 8444:31
denigration [1] - 8484:12
deny [1] - 8475:26
Department [1] -

8492:9
dependency [1] - 8465:25
depressed [4] - 8449:25, 8449:30, 8465:30, 8471:5
depression [8] - 8444:40, 8449:24, 8458:15, 8461:32, 8465:18, 8465:26, 8471:2, 8487:39
depressive [3] - 8470:41, 8470:42, 8471:1
depressogenic [1] - 8471:7
describe [2] - 8455:37, 8456:5
described [3] - 8460:27, 8461:16, 8467:35
deserved [1] - 8460:14
designs [1] - 8454:15
destabilize [1] - 8484:4
detect [1] - 8454:16
detection [1] - 8491:25
determining [1] - 8485:39
develop [6] - 8454:18, 8455:41, 8458:13, 8462:19, 8462:20, 8476:5
developed [1] - 8459:34
developing [5] - 8453:33, 8461:25, 8461:26, 8461:39, 8467:16
development [13] - 8447:35, 8449:21, 8451:45, 8453:28, 8453:33, 8455:26, 8456:7, 8461:28, 8462:7, 8462:15, 8465:35, 8478:16, 8483:8
developmental [5] - 8461:26, 8461:30, 8477:21, 8483:27, 8493:7
diagnoses [1] - 8449:23
diagnosis [11] - 8449:7, 8449:8, 8449:9, 8449:12, 8457:46, 8458:8, 8458:11, 8459:39, 8465:12, 8465:14, 8487:18
die [1] - 8490:40
difference [9] - 8455:32, 8455:35, 8461:8, 8472:20, 8477:39, 8488:24, 8488:26, 8488:28, 8492:34
differences [2] - 8488:22, 8488:43
different [11] - 8445:17, 8445:40, 8450:21, 8454:32, 8459:25, 8466:32, 8467:46, 8486:20, 8494:28, 8494:40, 8496:37
differentiate [1] - 8450:27
differently [1] - 8475:24
difficult [17] - 8444:40, 8447:42, 8454:1, 8455:3, 8459:36, 8459:45, 8467:47, 8469:22, 8469:33, 8475:20, 8482:39, 8484:8, 8493:47, 8494:6, 8494:11, 8494:17, 8494:21
Difficulties [1] - 8447:6
difficulties [12] - 8447:7, 8447:12, 8447:14, 8448:45, 8454:37, 8464:24, 8466:3, 8466:37, 8468:36, 8477:27, 8477:47, 8483:3
difficulty [8] - 8453:37, 8464:27, 8466:2, 8469:13, 8475:19, 8477:6, 8477:28, 8493:5
digging [1] - 8490:4
dinners [1] - 8473:25
direct [1] - 8470:43
directed [3] - 8443:16, 8469:5, 8469:13
direction [1] - 8468:12
dirty [2] - 8444:32, 8459:41
disaggregate [1] - 8493:44
discern [1] - 8464:5
disclose [6] - 8447:34, 8466:32, 8472:16, 8483:29, 8483:37, 8483:40
discloses [1] - 8479:36
disclosing [4] - 8447:26, 8447:37, 8483:21, 8489:30
Disclosure [1] - 8447:6
disclosure [13] - 8447:9, 8447:10, 8447:12, 8447:14, 8447:20, 8447:39, 8447:41, 8455:3, 8473:27, 8475:26, 8479:37, 8483:25, 8495:13
disclosures [6] - 8445:2, 8445:3, 8447:16, 8447:18, 8447:19, 8472:10
discomforted [1] - 8481:45
discredit [2] - 8478:43, 8478:46
discredited [1] - 8445:4
discrete [4] - 8449:22, 8449:24, 8487:27, 8487:28
discussed [2] - 8493:1, 8494:44
discussion [1] - 8470:35
discussions [1] - 8489:21
diseases [2] - 8463:45, 8466:25
disorder [8] - 8457:33, 8457:36, 8457:39, 8458:18, 8458:20, 8465:33, 8481:16
disorders [2] - 8465:10, 8480:28
disrupted [1] - 8461:27
dissociated [1] - 8459:25
distorts [1] - 8451:22
distress [5] - 8444:38, 8444:47, 8449:32, 8459:46, 8481:18
distressed [2] - 8464:43, 8464:47
disturbance [6] - 8456:43, 8458:9, 8459:37, 8461:33, 8478:33, 8478:35
disturbances [7] - 8443:4, 8462:40, 8464:22, 8464:23, 8465:37, 8465:38
disturbed [2] - 8456:43, 8461:34
disturbing [1] - 8472:21
doctor [7] - 8442:30, 8442:39, 8465:24, 8468:41, 8481:37, 8483:18, 8489:39
doctorate [1] - 8442:38
documented [2] - 8462:46, 8470:38
dog [1] - 8465:4
domestic [2] - 8487:35, 8487:36
dominant [1] - 8462:43
done [19] - 8446:47, 8447:3, 8447:25, 8448:44, 8448:47, 8452:21, 8452:33, 8452:41, 8452:45, 8454:18, 8455:15, 8462:29, 8468:9, 8469:38, 8475:22, 8475:33, 8476:6, 8490:13, 8492:13
double [1] - 8451:33
doubt [2] - 8459:34, 8470:33
down [7] - 8458:46, 8476:25, 8479:12, 8479:17, 8480:19, 8491:14, 8492:4
DPM [1] - 8442:32
DR [4] - 8495:35, 8496:21, 8496:26, 8496:32
Dr [2] - 8442:12, 8471:36
dramatic [2] - 8461:47, 8462:11
draw [1] - 8485:35
dread [2] - 8444:46, 8467:3
dreadful [1] - 8456:26
dream [1] - 8486:27
dreams [2] - 8459:7, 8464:21
drinking [1] - 8487:22
drive [3] - 8467:16, 8467:22, 8471:20
drives [1] - 8453:14
driving [2] - 8453:31, 8458:47
dropped [1] - 8492:19
drug [5] - 8466:21, 8466:22, 8482:12, 8490:20, 8490:21
drugs [7] - 8449:31, 8465:20, 8465:22, 8466:16, 8471:6, 8474:18
dysfunction [1] - 8449:24
dysfunctional [1] - 8473:41
dyspraxia [1] - 8480:27

E

early [4] - 8453:29, 8476:44, 8490:16, 8491:43
easier [1] - 8471:28
easily [3] - 8455:19, 8464:19, 8478:47
easy [8] - 8457:9, 8457:28, 8462:9, 8469:37, 8475:44, 8476:8, 8488:14, 8495:14
educate [1] - 8493:34
education [14] - 8444:18, 8444:36, 8449:29, 8455:15, 8469:10, 8469:24, 8469:27, 8469:35, 8469:37, 8469:47, 8470:1, 8470:7, 8470:23
effect [11] - 8448:45, 8456:9, 8460:47, 8463:20, 8464:8, 8468:24, 8471:7, 8472:16, 8472:17, 8478:15, 8482:42
effective [7] - 8445:37, 8448:42, 8453:44, 8453:47, 8454:13, 8460:34, 8479:45
effectively [4] - 8463:27, 8479:8, 8479:14, 8479:32
effects [8] - 8455:46, 8456:41, 8464:14, 8464:15, 8468:18, 8471:37, 8472:40
effort [1] - 8490:19
effort's [1] - 8465:31
either [7] - 8446:25, 8474:20, 8477:25, 8490:23, 8492:13, 8495:19, 8496:42
elaborate [1] - 8459:3
element [2] - 8447:20, 8460:6
elements [1] - 8488:1
eligible [1] - 8476:33
eliminates [2] -

8476:19, 8476:20
elucidate [1] - 8460:9
embarrassed [2] - 8480:22, 8486:2
emerge [1] - 8450:20
emotional [4] - 8453:28, 8462:23, 8464:18, 8475:4
empathy [1] - 8476:5
employment [2] - 8449:30, 8494:38
enacting [1] - 8467:19
end [5] - 8460:11, 8460:29, 8467:19, 8470:36, 8477:46
ends [1] - 8461:29
energy [1] - 8458:6
engagements [1] - 8482:18
engine [2] - 8463:32, 8463:33
England [2] - 8443:47, 8452:43
enormous [4] - 8450:36, 8467:1, 8473:3, 8477:13
enormously [1] - 8472:13
enquiry [5] - 8495:36, 8496:4, 8496:5, 8496:10, 8496:11
ensure [1] - 8490:11
entering [1] - 8455:14
entire [4] - 8456:15, 8458:1, 8465:35, 8472:8
entirely [1] - 8476:4
entitled [1] - 8469:42
entry [1] - 8455:28
environment [14] - 8444:21, 8444:39, 8450:1, 8451:35, 8453:22, 8453:35, 8453:39, 8455:38, 8458:24, 8485:24, 8485:44, 8486:36, 8487:8
equipped [1] - 8468:42
especially [10] - 8449:10, 8451:7, 8468:10, 8468:33, 8471:41, 8474:11, 8475:20, 8484:24, 8484:28, 8493:26
essential [1] - 8487:9
essential [1] - 8493:4
establish [3] - 8459:28, 8473:19, 8473:22
established [1] - 8472:29
establishing [3] - 8466:2, 8473:26, 8474:23
estimate [1] - 8494:29
ethicist [1] - 8446:41
Europe [1] - 8446:19
evaluation [2] - 8466:35, 8466:38
event [1] - 8496:38
events [1] - 8493:45
eventually [1] - 8463:34
everywhere [1] - 8445:5
evidence [19] - 8442:14, 8472:37, 8473:7, 8478:15, 8478:17, 8479:46, 8480:9, 8483:22, 8484:11, 8485:9, 8488:20, 8488:40, 8489:19, 8492:43, 8492:44, 8492:45, 8492:46, 8495:28, 8495:45
exacerbate [1] - 8471:8
EXAMINATION [2] - 8442:21, 8492:41
examine [2] - 8459:33, 8496:15
examined [3] - 8495:39, 8496:14, 8496:30
examining [1] - 8486:47
example [17] - 8448:5, 8450:35, 8453:16, 8457:7, 8457:44, 8458:45, 8461:42, 8462:31, 8473:16, 8474:31, 8483:10, 8483:47, 8484:2, 8484:37, 8486:19, 8487:34, 8491:1
except [1] - 8463:8
excessive [1] - 8466:7
exclusive [3] - 8474:12, 8475:41, 8477:37
exclusively [3] - 8453:17, 8455:33, 8473:47
excused [2] - 8495:28, 8495:37
expands [1] - 8493:37
expectancy [2] - 8463:47, 8464:1
expected [1] - 8494:28
experience [22] - 8445:41, 8447:21, 8447:29, 8450:47, 8451:25, 8455:21, 8457:22, 8467:20, 8467:26, 8467:30, 8469:44, 8472:27, 8477:16, 8478:18, 8480:18, 8481:30, 8481:44, 8485:20, 8489:10, 8489:23, 8494:2, 8495:1
experienced [5] - 8447:27, 8468:2, 8476:6, 8481:25, 8493:19
experiences [5] - 8445:28, 8456:26, 8468:45, 8478:24, 8489:36
experiencing [2] - 8493:5, 8493:10
experimental [1] - 8454:15
expertise [1] - 8468:15
explain [1] - 8488:21
exploited [2] - 8466:20, 8466:21
exponentially [1] - 8493:37
exposed [1] - 8488:6
exposure [2] - 8469:9, 8484:47
expressions [1] - 8463:43
extensive [2] - 8451:6, 8451:9
extent [2] - 8448:27, 8448:29
externalisers [1] - 8477:31
externalising [2] - 8477:35, 8477:42
extraordinarily [2] - 8450:40, 8490:33
extremely [9] - 8444:26, 8445:28, 8447:21, 8448:36, 8450:23, 8451:44, 8456:36, 8459:40, 8487:33
eye [3] - 8454:20, 8454:22, 8454:25

F

face [1] - 8486:14
facilitate [1] - 8487:7
fact [4] - 8445:33, 8474:37, 8486:14, 8488:25
factor [4] - 8453:30, 8456:23, 8456:31, 8491:37
factors [6] - 8453:12, 8471:21, 8473:1, 8485:22, 8485:39, 8487:18
faculty [1] - 8442:35
Faculty [1] - 8447:45
fairly [9] - 8443:45, 8448:4, 8452:6, 8453:10, 8474:12, 8477:5, 8492:30, 8494:37, 8495:11
faith [11] - 8446:30, 8446:31, 8446:32, 8446:35, 8450:37, 8450:38, 8451:26, 8452:46, 8454:14, 8471:45, 8484:3
faith-based [1] - 8454:14
faiths [3] - 8446:12, 8446:13, 8484:45
falls [1] - 8472:30
false [8] - 8472:28, 8489:28, 8495:4, 8495:10, 8495:12, 8495:15, 8495:17, 8495:18
familial [5] - 8443:7, 8452:10, 8477:23, 8482:32, 8491:32
familiar [4] - 8457:37, 8465:29, 8475:12, 8487:2
families [10] - 8445:23, 8445:24, 8445:27, 8490:13, 8490:30, 8490:32, 8491:38, 8491:39, 8491:44, 8492:4
family [32] - 8442:27, 8443:21, 8444:29, 8448:25, 8451:7, 8457:9, 8461:21, 8462:31, 8462:32, 8462:34, 8464:30, 8472:8, 8472:12, 8473:18, 8473:25, 8480:21, 8482:44, 8482:45, 8484:6, 8484:7, 8485:24, 8487:11, 8487:17, 8490:10, 8490:27, 8490:37, 8491:33, 8494:22, 8494:34, 8494:35
family's [1] - 8483:39
famous [1] - 8489:15
fantasies [2] - 8455:2, 8467:22
fantasy [3] - 8467:18, 8467:40, 8467:47
far [5] - 8449:35, 8450:28, 8480:9, 8486:4, 8486:33
Father [2] - 8442:14, 8495:45
fault [1] - 8459:44
favourite [1] - 8482:47
fear [5] - 8444:45, 8463:43, 8467:3, 8467:34, 8467:36
fearful [3] - 8477:44, 8489:33
feasible [1] - 8469:31
features [1] - 8473:16
fed [1] - 8462:4
feed [2] - 8462:19, 8464:26
feeds [2] - 8466:9, 8471:27
feelings [10] - 8459:33, 8459:36, 8460:29, 8461:35, 8461:42, 8465:21, 8466:11, 8467:38, 8480:23, 8483:22
Fellow [1] - 8442:33
felt [2] - 8480:22, 8482:36
female [4] - 8454:21, 8488:42, 8489:1
females [1] - 8454:21
few [4] - 8443:13, 8444:41, 8457:41, 8476:20
field [2] - 8470:28, 8485:32
figures [4] - 8452:15, 8452:19, 8452:21, 8452:39
findings [1] - 8443:39
fine [2] - 8456:9, 8494:5
firm [1] - 8484:2
firmly [1] - 8473:27
first [9] - 8442:3, 8443:27, 8443:29, 8456:3, 8467:45, 8476:1, 8480:45, 8486:14, 8488:4
First [1] - 8478:32
firstly [3] - 8455:45, 8465:9, 8470:35
fit [3] - 8449:8,

8450:43, 8475:24
fits [2] - 8451:17,
8488:33
five [1] - 8472:24
fixed [1] - 8442:10
flashback [3] -
8467:18, 8467:46,
8468:5
flashbacks [5] -
8459:7, 8467:17,
8468:1, 8471:18,
8478:17
flickering [1] - 8458:4
flourish [1] - 8446:42
focus [4] - 8449:23,
8460:47, 8476:7,
8483:23
focused [1] - 8449:11
follow [1] - 8492:18
following [2] -
8448:33, 8486:45
follows [1] - 8466:26
food [1] - 8462:15
foolproof [1] -
8454:26
force [2] - 8466:41,
8484:21
forensic [3] - 8442:28,
8442:35, 8442:36
forgot [1] - 8479:10
forgotten [2] -
8479:43, 8479:44
form [8] - 8449:27,
8452:5, 8454:6,
8456:34, 8460:26,
8460:41, 8475:46,
8481:22
formed [1] - 8455:21
forms [3] - 8481:25,
8484:14, 8491:45
forth [3] - 8448:25,
8454:34, 8491:25
fortune [1] - 8488:11
forum [1] - 8446:8
foster [1] - 8491:38
four [2] - 8472:24,
8476:32
frank [1] - 8484:17
free [1] - 8486:36
frequently [1] - 8457:7
Friday [1] - 8496:38
friend [4] - 8462:32,
8495:32, 8496:4,
8496:10
friends [1] - 8451:8
friends' [1] - 8451:8
frightened [1] -
8464:19
full [5] - 8442:24,
8455:3, 8458:18,

8462:3, 8478:26
fuller [2] - 8477:6
fully [1] - 8448:28
function [6] - 8449:22,
8449:28, 8458:1,
8461:34, 8462:34,
8464:41
functional [2] -
8466:3, 8473:41
functioning [7] -
8456:46, 8457:45,
8466:35, 8474:44,
8474:45, 8490:14,
8491:1
functions [1] - 8478:9
fundamental [6] -
8455:30, 8459:37,
8460:19, 8470:17,
8471:27, 8478:34
funding [5] - 8446:22,
8446:23, 8446:24,
8482:10
Furness [6] - 8441:39,
8442:1, 8442:6,
8495:23, 8495:42,
8496:46
FURNESS [18] -
8442:3, 8442:8,
8442:21, 8442:23,
8450:43, 8455:44,
8456:39, 8461:8,
8464:13, 8470:22,
8471:36, 8483:15,
8489:39, 8492:36,
8495:25, 8495:32,
8495:44, 8497:1
Furness's [1] -
8484:43
futile [1] - 8445:8
future [1] - 8486:5

G

Gail [1] - 8441:39
gathered [1] - 8446:19
gender [3] - 8442:40,
8443:20
gene [3] - 8487:39,
8487:40
Gene [1] - 8454:17
general [12] - 8448:23,
8452:8, 8454:30,
8454:46, 8455:25,
8457:1, 8457:2,
8469:43, 8475:4,
8478:13, 8480:37,
8483:20
generally [10] -
8443:19, 8450:26,
8461:4, 8461:10,
8481:12, 8482:22,

8482:30, 8485:10,
8488:27, 8488:34
generous [1] -
8443:45
genes [1] - 8487:37
genuine [2] - 8467:21,
8475:23
girl [2] - 8452:4,
8477:44
girls [6] - 8452:16,
8466:23, 8477:31,
8477:35, 8477:38,
8479:5
given [9] - 8462:8,
8462:22, 8466:32,
8479:20, 8483:21,
8485:9, 8488:20,
8492:45, 8492:46
global [2] - 8446:29,
8446:35
gobbledygook [1] -
8481:15
God [1] - 8471:42
God's [2] - 8471:45,
8472:3
Google [1] - 8462:10
governments [1] -
8444:9
GPs [4] - 8480:45,
8480:46, 8481:10,
8481:13
gradually [1] -
8451:10
gratification [1] -
8466:18
Gray [2] - 8496:1,
8496:34
GRAY [5] - 8496:4,
8496:9, 8496:17,
8496:36, 8496:44
great [4] - 8453:37,
8470:32, 8481:30,
8488:26
greater [2] - 8452:34,
8463:1
greatest [1] - 8488:5
Green [1] - 8495:36
green [3] - 8495:37,
8496:1, 8496:14
Grenville [1] - 8441:21
grew [1] - 8487:34
grief [2] - 8494:17,
8494:18
grip [1] - 8468:10
groomed [5] -
8445:36, 8445:39,
8451:4, 8473:11,
8473:12
grooming [27] -
8445:37, 8450:43,

8450:45, 8451:1,
8451:7, 8451:9,
8451:16, 8451:21,
8460:31, 8473:7,
8473:9, 8473:14,
8473:15, 8473:16,
8473:17, 8473:18,
8473:39, 8483:45,
8484:6, 8484:10,
8484:15, 8484:19,
8484:22
grooming's [1] -
8460:34
grossly [3] - 8462:6,
8462:7, 8494:36
group [16] - 8443:35,
8443:38, 8445:18,
8446:30, 8446:36,
8447:2, 8452:46,
8455:35, 8455:39,
8456:40, 8457:24,
8482:40, 8489:13,
8494:43
groups [6] - 8446:1,
8446:31, 8446:32,
8453:9, 8481:40,
8481:41
growing [2] - 8461:25,
8470:28
grows [1] - 8472:2
growth [1] - 8458:6
guilt [5] - 8459:34,
8460:5, 8476:20,
8483:22, 8483:41
guilty [1] - 8460:11

H

hand [2] - 8458:33,
8458:38
handle [1] - 8468:28
HANSCOMBE [1] -
8495:35
happen" [1] - 8475:27
happily [1] - 8494:26
hard [12] - 8444:19,
8448:36, 8456:14,
8467:17, 8475:34,
8475:42, 8480:31,
8484:4, 8485:29,
8485:43, 8487:28,
8490:21
harder [3] - 8456:36,
8477:7
hardiness [2] -
8485:28
hardy [1] - 8485:25
harm [4] - 8444:46,
8476:5, 8489:30,
8493:36
health [16] - 8442:41,

8443:20, 8473:4,
8473:5, 8477:8,
8477:47, 8480:12,
8487:1, 8487:6,
8487:10, 8487:12,
8487:14, 8487:24,
8487:47, 8488:2
Health [1] - 8492:9
healthy [1] - 8485:23
hear [2] - 8458:35,
8496:36
heard [4] - 8448:43,
8483:24, 8484:11,
8486:40
Hearing [1] - 8441:16
hearings [2] - 8460:3,
8489:20
heavy [1] - 8465:21
held [1] - 8464:36
help [10] - 8446:18,
8449:13, 8460:42,
8467:37, 8468:8,
8469:14, 8481:40,
8482:3, 8482:39,
8489:45
helped [1] - 8446:10
helpful [4] - 8449:15,
8469:7, 8481:28,
8481:34
hemisphere [1] -
8462:43
hemispheres [1] -
8462:44
herself [2] - 8489:2,
8489:11
hierarchical [2] -
8453:8, 8453:10
hierarchy [1] - 8453:7
high [4] - 8445:26,
8452:27, 8457:19,
8493:19
higher [4] - 8474:15,
8491:26, 8491:27
highly [5] - 8453:6,
8453:39, 8457:18,
8458:37, 8493:19
himself [1] - 8496:29
hippocampus [2] -
8462:41, 8462:42
history [8] - 8454:30,
8454:33, 8454:35,
8478:6, 8480:24,
8487:20, 8487:22,
8489:1
hold [1] - 8467:7
holistic [2] - 8449:14,
8449:18
home [19] - 8451:34,
8473:26, 8484:7,
8489:40, 8489:44,

8489:47, 8490:3,
8490:8, 8490:12,
8490:22, 8490:27,
8490:29, 8490:35,
8490:41, 8491:18,
8492:14, 8492:15,
8492:19, 8492:21
homeland [1] -
8444:29
homes [2] - 8489:44,
8490:46
homosexual [1] -
8465:43
Honour [7] - 8442:3,
8442:17, 8483:15,
8495:25, 8495:32,
8495:44, 8497:2
Honour's [1] - 8496:9
horrific [1] - 8485:20
hospitalised [2] -
8487:20, 8487:22
hospitals [1] -
8442:44
hours [4] - 8469:36,
8469:38, 8470:26
household [1] -
8487:35
huge [18] - 8447:14,
8448:8, 8449:1,
8452:2, 8454:18,
8458:8, 8477:27,
8477:47, 8478:27,
8478:30, 8481:14,
8487:17, 8488:15,
8488:46, 8492:33,
8494:16, 8494:18
human [5] - 8456:24,
8462:5, 8465:6,
8468:2, 8486:22
humiliation [1] -
8484:12
hurt [1] - 8478:11
hurting [1] - 8464:34
hurts [1] - 8447:40
hyper [2] - 8480:26,
8480:41
hyperactive [1] -
8466:6
hyperamnesia [1] -
8459:14
hyperarousal [7] -
8457:44, 8457:45,
8457:47, 8458:7,
8458:21, 8459:6,
8463:32
hypervigilance [1] -
8458:22
hypervigilant [2] -
8458:23, 8465:47
hypoaesthesia [1] -

8459:15

I

idea [4] - 8444:5,
8449:7, 8467:40,
8490:8
ideal [1] - 8475:32
ideas [2] - 8455:22,
8487:46
identical [1] - 8494:35
identified [1] - 8493:8
identify [1] - 8493:32
identifying [2] -
8455:25, 8494:46
identity [4] - 8465:39,
8472:21, 8472:30,
8494:20
ignored [1] - 8481:18
ill [2] - 8473:4, 8473:5
ill-health [2] - 8473:4,
8473:5
illness [10] - 8463:40,
8463:44, 8470:41,
8470:42, 8471:1,
8472:45, 8478:3,
8478:5, 8487:20
illnesses [1] - 8487:13
illustration [1] -
8462:1
image [1] - 8459:13
imagery [4] - 8459:8,
8468:3, 8468:5,
8478:26
imagine [2] - 8493:32,
8493:40
imagining [1] -
8493:39
immature [2] -
8453:38, 8474:46
immaturity [2] -
8475:4, 8475:5
immediate [1] -
8473:28
immediately [2] -
8453:40, 8466:38
immune [1] - 8463:39
impact [8] - 8458:1,
8460:6, 8462:25,
8483:44, 8488:20,
8488:22, 8488:36,
8488:44
impacts [2] - 8459:4,
8465:9
important [20] -
8453:13, 8458:25,
8459:27, 8467:45,
8468:8, 8468:31,
8469:8, 8470:29,
8471:39, 8472:7,
8478:20, 8481:29,
8481:39, 8482:34,
8482:36, 8482:38,
8482:42, 8485:39,
8488:11, 8489:29
imposed [1] - 8468:29
imposing [1] -
8468:33
impossible [2] -
8450:7, 8494:7
improvement [1] -
8469:6
impulse [1] - 8467:39
inability [2] - 8459:6,
8459:11
incidence [1] -
8490:34
incidences [2] -
8477:12, 8491:23
includes [2] -
8452:10, 8456:40
including [4] -
8451:16, 8451:26,
8470:26, 8478:16
incorporate [1] -
8468:19
increased [1] -
8472:38
increases [1] -
8491:36
indeed [2] - 8442:13,
8479:35
independent [1] -
8482:6
indicate [5] - 8442:3,
8442:9, 8442:12,
8469:7, 8480:47
indicated [3] -
8473:30, 8476:14,
8476:36
individual [8] -
8443:1, 8446:44,
8456:27, 8456:32,
8489:44, 8490:30,
8490:46, 8493:9
inducted [1] - 8455:19
induction [1] -
8455:40
infancy [1] - 8491:10
infant [5] - 8490:47,
8491:9, 8491:11,
8491:46, 8492:1
influence [2] -
8442:40, 8443:20
influences [1] -
8488:7
informal [1] - 8494:43
information [2] -
8454:3, 8463:5
informed [8] -

8468:16, 8468:17,
8468:23, 8468:35,
8468:44, 8469:39,
8480:10, 8481:21
innate [3] - 8485:9,
8485:28, 8485:43
innocence [1] -
8475:31
innocent [1] - 8458:43
insofar [1] - 8455:16
instance [2] -
8494:32, 8494:46
instances [1] -
8478:40
instantly [1] - 8487:23
institute [1] - 8492:30
institution [10] -
8444:16, 8444:43,
8445:4, 8452:24,
8452:40, 8455:10,
8458:47, 8468:41,
8481:46, 8486:15
institutional [15] -
8443:7, 8443:13,
8443:28, 8451:26,
8451:36, 8452:7,
8452:14, 8452:17,
8477:23, 8482:47,
8484:28, 8486:9,
8488:43, 8491:20
INSTITUTIONAL [1] -
8441:11
institutions [21] -
8444:4, 8444:23,
8450:47, 8451:33,
8452:22, 8452:24,
8452:33, 8452:47,
8454:14, 8454:45,
8455:4, 8460:27,
8473:10, 8482:2,
8482:3, 8484:24,
8486:7, 8486:13,
8486:16, 8486:32,
8486:43
instructions [1] -
8495:39
intact [2] - 8445:23,
8445:27
intellectually [1] -
8459:43
intelligent [1] -
8485:23
intense [2] - 8459:11,
8471:18
intensely [2] -
8458:38, 8460:41
intensity [1] - 8479:41
intensive [1] - 8476:29
interest [2] - 8455:31,
8473:36

interested [11] -
8446:23, 8446:24,
8453:20, 8460:41,
8469:2, 8470:8,
8474:1, 8474:33,
8482:37, 8486:47,
8487:47
interesting [4] -
8445:16, 8445:17,
8446:13, 8446:20
interests [1] - 8490:26
internalise [2] -
8460:21, 8477:36
internalisers [1] -
8477:32
interstate [1] -
8454:34
intervention [2] -
8490:16, 8491:44
interview [1] - 8493:13
intimacy [1] - 8466:4
intimidated [2] -
8480:36, 8489:27
INTO [1] - 8441:11
intrafamilial [1] -
8443:12
intuitive [2] - 8483:32,
8483:34
intuitively [2] -
8483:30, 8483:39
invited [1] - 8446:11
involve [1] - 8449:19
involved [4] - 8443:27,
8445:46, 8455:40,
8475:8
involves [1] - 8476:29
Ireland [1] - 8452:43
irrelevant [1] - 8481:3
isolate [1] - 8494:3
isolated [1] - 8444:15
issue [11] - 8442:4,
8442:10, 8446:28,
8447:14, 8450:45,
8452:26, 8452:28,
8453:13, 8455:17,
8483:23, 8493:30
issues [6] - 8442:40,
8446:41, 8446:45,
8455:26, 8483:19,
8493:8
it'll [1] - 8457:26
itself [9] - 8444:7,
8447:21, 8447:39,
8450:6, 8451:40,
8468:26, 8468:35,
8469:32, 8473:45

J

Jennifer [1] - 8441:34

jeopardy [1] - 8451:33
Jewish [1] - 8485:4
job [1] - 8473:42
jobs [1] - 8473:41
judged [1] - 8459:30
JUSTICE [1] - 8483:18
Justice [2] - 8441:32,
8441:34

K

keep [5] - 8466:36,
8476:10, 8486:23,
8486:25, 8486:41
keeping [3] - 8479:39,
8479:45, 8486:34
keeps [1] - 8459:12
kept [2] - 8445:3,
8483:6
key [1] - 8478:13
keynote [1] - 8447:5
kicked [1] - 8465:4
kid [6] - 8477:43,
8480:20, 8480:26,
8480:30, 8480:40,
8480:41
kidney [1] - 8494:4
kids [2] - 8480:17,
8480:39
killing [1] - 8471:29
kind [36] - 8447:29,
8447:32, 8449:21,
8449:31, 8450:36,
8451:12, 8451:29,
8454:47, 8457:44,
8459:26, 8460:33,
8461:39, 8462:3,
8463:41, 8463:42,
8464:37, 8464:38,
8464:41, 8466:17,
8466:18, 8467:2,
8467:7, 8467:15,
8467:17, 8469:9,
8470:3, 8471:20,
8471:44, 8473:36,
8474:30, 8483:34,
8485:27, 8491:27,
8492:32, 8493:22
kindergarten [1] -
8480:24
kinds [7] - 8445:17,
8456:43, 8459:2,
8465:33, 8481:19,
8482:41, 8487:13
knowledge [3] -
8447:1, 8468:18,
8469:43
known [9] - 8446:34,
8448:3, 8448:4,
8448:5, 8448:10,

8448:19, 8448:20,
8465:4, 8489:22
knows [1] - 8490:38

L

label [1] - 8478:9
labels [1] - 8480:28
labour [1] - 8444:19
lack [1] - 8485:28
large [2] - 8460:6,
8493:17
larger [1] - 8452:14
largest [1] - 8444:24
last [5] - 8448:47,
8484:29, 8484:33,
8488:39, 8492:44
late [1] - 8443:32
law [2] - 8450:26,
8474:22
lead [3] - 8455:10,
8455:27, 8460:17
leaking [2] - 8480:1,
8480:4
leap [1] - 8467:42
learn [1] - 8493:34
learned [2] - 8496:4,
8496:10
learning [2] - 8446:28,
8480:27
learnings [2] -
8446:27, 8477:4
learnt [3] - 8446:34,
8451:24, 8455:6
least [1] - 8474:32
leave [1] - 8490:11
leaving [3] - 8472:39,
8476:14, 8490:30
led [1] - 8444:39
left [5] - 8444:4,
8444:42, 8463:18,
8476:44, 8476:45
less [11] - 8455:39,
8457:24, 8457:28,
8463:10, 8463:12,
8463:14, 8467:21,
8467:23, 8473:2,
8484:19, 8487:7
lesser [1] - 8464:10
level [10] - 8456:20,
8464:6, 8469:42,
8469:43, 8470:32,
8474:15, 8483:34,
8485:43, 8486:24,
8486:41
levels [2] - 8450:21,
8458:6
lie [2] - 8472:29,
8495:2
lied [1] - 8476:24

lies [1] - 8488:41
life [23] - 8445:30,
8447:29, 8455:21,
8456:16, 8459:10,
8459:46, 8462:34,
8463:47, 8466:31,
8466:40, 8471:10,
8472:28, 8473:2,
8479:7, 8479:39,
8480:7, 8493:4,
8493:33, 8493:44,
8494:20, 8494:29
lifestyles [1] - 8472:46
light [1] - 8475:25
likely [29] - 8455:39,
8457:24, 8457:27,
8457:28, 8457:31,
8458:11, 8458:13,
8461:11, 8461:14,
8463:1, 8463:10,
8463:12, 8463:14,
8464:5, 8464:44,
8464:47, 8466:12,
8466:23, 8466:24,
8466:25, 8467:13,
8467:21, 8467:23,
8468:24, 8477:33,
8477:35, 8479:37,
8487:35, 8491:40
limited [1] - 8461:11
lines [1] - 8453:34
listen [4] - 8479:18,
8483:40, 8486:40,
8493:34
listened [1] - 8486:37
literature [2] -
8455:45, 8495:4
litigated [1] - 8448:6
litigation [4] -
8445:11, 8445:12,
8445:43, 8446:4
littler [1] - 8480:39
live [3] - 8444:45,
8467:2, 8472:42
liver [1] - 8494:4
lives [3] - 8444:40,
8456:15, 8494:37
living [5] - 8447:31,
8462:24, 8471:10,
8490:30, 8494:37
lobby [1] - 8448:44
lobbying [2] -
8448:43, 8481:41
lock [1] - 8478:12
long-term [1] -
8455:46
longevity [1] -
8472:40
Look [1] - 8479:30
look [20] - 8446:40,

8453:47, 8454:19,
8454:20, 8454:38,
8454:44, 8454:46,
8456:9, 8458:20,
8459:20, 8461:4,
8465:31, 8471:10,
8477:5, 8480:26,
8486:6, 8487:47,
8488:9, 8494:24,
8494:35
looked [4] - 8443:17,
8443:20, 8454:11,
8454:37
looking [9] - 8445:17,
8446:41, 8473:45,
8481:21, 8484:28,
8485:38, 8487:39,
8491:24, 8491:39
looks [2] - 8450:26,
8459:1
lose [1] - 8450:38
loss [3] - 8444:28,
8450:37, 8471:45
lost [2] - 8478:12,
8494:20
love [1] - 8464:33
loved [2] - 8473:20,
8485:26
low [1] - 8476:36
lying [3] - 8445:5,
8472:11, 8475:28

M

Magistrates' [1] -
8441:20
main [2] - 8448:39,
8488:1
major [3] - 8442:44,
8446:12, 8446:15
majority [4] - 8467:12,
8474:11, 8477:9,
8488:41
male [6] - 8454:22,
8455:18, 8465:39,
8465:42, 8489:14,
8489:16
males [1] - 8454:21
malleable [2] -
8455:20, 8463:3
Malta [1] - 8443:41
man [3] - 8453:28,
8453:38, 8455:14
managed [1] -
8479:14
management [1] -
8443:2
mandate [1] - 8469:34
manifest [1] - 8457:40
manipulated [2] -
8451:10, 8460:37
manipulation [3] -
8450:33, 8450:46,
8451:13
manipulative [1] -
8475:29
manual [1] - 8444:19
MARICH [3] - 8496:21,
8496:26, 8496:32
marked [1] - 8452:47
married [2] - 8447:30,
8494:26
marry [2] - 8474:10
massive [3] - 8458:44,
8486:20, 8487:38
master [1] - 8465:5
matter [2] - 8443:29,
8489:24
MAY [1] - 8497:7
MBBS [1] - 8442:32
McClellan [1] -
8441:32
McInerney [2] -
8442:14, 8495:45
mean [11] - 8448:25,
8449:5, 8449:41,
8449:43, 8456:31,
8469:41, 8472:4,
8472:32, 8474:17,
8479:29, 8486:20
meaning [4] -
8450:15, 8457:44,
8477:32, 8477:36
means [5] - 8458:2,
8463:41, 8465:43,
8468:36, 8472:9
measure [2] -
8454:20, 8454:22
measures [1] -
8454:44
measuring [1] -
8454:24
mechanism [2] -
8470:40, 8479:24
media [3] - 8446:34,
8448:9, 8484:47
medical [3] - 8442:32,
8443:18, 8449:7
medicating [1] -
8449:32
medication [5] -
8449:12, 8449:15,
8459:19, 8465:25,
8480:29
medicine [2] -
8442:33, 8449:16
Member [1] - 8441:32
member [4] - 8461:21,
8464:30, 8471:41,
8473:20

members [3] - 8443:24, 8482:45
memories [3] - 8458:25, 8471:19, 8479:25
memory [21] - 8459:8, 8461:35, 8462:39, 8462:40, 8478:16, 8478:18, 8478:20, 8478:23, 8478:30, 8478:31, 8478:34, 8478:35, 8478:37, 8478:38, 8478:47, 8479:4, 8479:9, 8479:23, 8493:7
men [19] - 8443:23, 8443:32, 8443:40, 8444:25, 8445:6, 8453:15, 8453:32, 8455:9, 8465:47, 8466:2, 8474:31, 8474:33, 8477:24, 8477:47, 8478:3, 8478:5, 8488:41, 8489:22, 8492:43
mental [8] - 8442:40, 8442:41, 8443:20, 8462:7, 8477:8, 8477:47, 8480:12, 8487:20
mentioned [2] - 8450:4, 8487:32
merely [1] - 8456:33
merit [1] - 8493:16
Mexico [1] - 8452:44
middle [1] - 8462:43
might [21] - 8444:29, 8444:46, 8458:33, 8464:16, 8469:7, 8470:12, 8471:31, 8473:42, 8480:47, 8483:3, 8483:47, 8486:6, 8486:7, 8487:7, 8487:47, 8493:33, 8493:41, 8494:13, 8494:19, 8494:21
migrants [3] - 8443:42, 8443:43, 8443:45
migration [1] - 8444:7
milk [1] - 8487:22
mind [13] - 8450:11, 8450:12, 8450:34, 8450:47, 8451:14, 8458:28, 8459:13, 8463:29, 8463:30, 8468:1, 8478:25, 8479:6, 8488:40
mindful [1] - 8480:15
minds [1] - 8480:6
minimise [2] - 8486:7, 8486:13
ministers [2] - 8474:3, 8474:8
minority [5] - 8454:40, 8474:45, 8475:2, 8476:25
missed [1] - 8480:38
missing [1] - 8478:24
mistrustful [1] - 8458:23
misunderstood [1] - 8457:7
model [7] - 8487:1, 8487:6, 8487:24, 8487:47, 8488:2, 8489:46, 8490:45
modus [1] - 8489:7
MOLONEY [3] - 8492:41, 8492:43, 8495:21
moment [2] - 8469:19, 8483:23
Monday [1] - 8441:26
money [6] - 8466:17, 8482:6, 8482:15, 8486:19, 8486:23, 8487:38
money" [1] - 8466:19
months [1] - 8476:32
morbidity [4] - 8473:4, 8477:8, 8487:13, 8487:18
morning [5] - 8473:8, 8483:45, 8495:46, 8497:2, 8497:4
most [20] - 8449:23, 8451:40, 8451:41, 8452:36, 8452:38, 8453:9, 8456:26, 8456:34, 8457:4, 8457:5, 8457:36, 8459:27, 8461:47, 8467:2, 8477:24, 8478:5, 8482:23, 8489:43, 8490:29, 8495:13
mostly [4] - 8443:40, 8443:41, 8445:23, 8464:22
mother [9] - 8490:20, 8490:47, 8491:2, 8491:5, 8491:9, 8491:11, 8491:46, 8492:1, 8492:17
mother-infant [3] - 8491:9, 8491:11, 8492:1
mothers [6] - 8444:1, 8444:3, 8444:4, 8444:34, 8491:6, 8492:10
motivated [2] - 8475:24, 8475:44
motivation [3] - 8495:11, 8495:15, 8495:16
motivations [1] - 8489:32
move [9] - 8454:12, 8454:34, 8455:46, 8470:12, 8470:13, 8476:1, 8477:12, 8479:33, 8491:17
moved [2] - 8454:32, 8480:23
movements [1] - 8454:20
MS [18] - 8442:3, 8442:8, 8442:21, 8442:23, 8450:43, 8455:44, 8456:39, 8461:8, 8464:13, 8470:22, 8471:36, 8483:15, 8489:39, 8492:36, 8495:25, 8495:32, 8495:44, 8497:1
muddled [1] - 8478:42
mum [2] - 8484:2, 8484:5
mums [1] - 8492:18
MURRAY [3] - 8460:1, 8468:38, 8486:45
Murray [1] - 8441:35
Muslim [1] - 8485:5
must [2] - 8460:13, 8476:6

N

name [3] - 8442:24, 8465:14, 8489:29
nature [1] - 8486:22
nearly [6] - 8469:25, 8490:19, 8490:37, 8490:47, 8491:5, 8491:10
neatly [1] - 8449:8
necessarily [6] - 8451:40, 8456:25, 8458:18, 8465:28, 8468:34, 8493:6
necessary [3] - 8483:8, 8483:11, 8483:12
need [29] - 8449:14, 8451:3, 8454:37, 8459:25, 8459:27, 8459:35, 8462:15, 8462:16, 8462:17, 8468:27, 8468:28, 8473:12, 8475:22, 8475:43, 8477:11, 8480:9, 8480:11, 8480:14, 8480:38, 8480:46, 8481:22, 8486:18, 8486:33, 8486:39, 8490:9, 8490:23, 8490:36
needed [1] - 8496:32
needs [4] - 8481:1, 8481:13, 8483:6, 8493:23
negative [3] - 8447:36, 8471:8, 8472:12
neglect [3] - 8488:5, 8488:9, 8490:41
neglected [1] - 8485:26
neglectful [1] - 8451:35
nervousness [1] - 8457:1
Netherlands [1] - 8452:44
neurological [4] - 8461:45, 8462:25, 8463:10, 8463:19
never [5] - 8447:30, 8479:13, 8480:2, 8494:45, 8495:1
New [9] - 8442:27, 8442:34, 8475:11, 8475:15, 8475:47, 8491:9, 8492:23, 8492:27, 8492:28
new [6] - 8446:27, 8446:28, 8457:10, 8461:28, 8477:4, 8492:9
news [1] - 8458:34
nice [2] - 8470:8, 8486:26
nobody [2] - 8446:22, 8480:29
nods [2] - 8477:18, 8489:41
non [4] - 8451:16, 8456:8, 8464:22, 8464:23
non-contact [1] - 8451:16
non-specific [2] - 8464:22, 8464:23
non-symptomatic [1] - 8456:8
normal [4] - 8454:44, 8462:31, 8462:34, 8493:44
normally [1] - 8474:40
North [1] - 8446:20
noses [2] - 8487:14, 8487:41
notable [1] - 8489:13
note [1] - 8488:44
nothing [7] - 8453:4, 8471:11, 8472:33, 8479:31, 8483:16, 8486:18, 8495:25
noticed [2] - 8442:6, 8442:8
notion [1] - 8493:36
number [10] - 8444:24, 8446:7, 8452:29, 8452:42, 8472:38, 8473:46, 8475:10, 8475:12, 8490:40, 8493:17
numbers [8] - 8443:11, 8452:1, 8452:2, 8452:3, 8452:27, 8452:34, 8452:35, 8470:36
nuns [3] - 8489:34, 8489:36, 8489:37
nurses [1] - 8492:15

O

objects [1] - 8453:17
obligation [1] - 8486:3
observations [2] - 8494:11, 8494:13
observe [1] - 8481:11
obviously [9] - 8453:21, 8453:34, 8454:2, 8454:35, 8455:18, 8457:29, 8461:41, 8473:35, 8474:4
occasionally [3] - 8482:25, 8489:15, 8489:37
occupation [1] - 8442:24
occupied [3] - 8449:6, 8458:27, 8458:39
occur [2] - 8457:6, 8464:23
occurred [1] - 8449:11
occurs [4] - 8446:35, 8448:40, 8456:21, 8470:40
offence [1] - 8488:41
offences [1] - 8476:38
offend [1] - 8488:47
offender [25] - 8445:36, 8450:34, 8451:10, 8455:33,

8460:30, 8465:40,
8473:19, 8473:31,
8475:11, 8475:12,
8475:13, 8475:15,
8475:47, 8476:2,
8476:31, 8476:47,
8484:1, 8484:7,
8484:20, 8484:33,
8488:25, 8488:42,
8489:1, 8489:14,
8489:17

offender's [2] -
8465:42, 8490:5

offenders [29] -
8453:22, 8454:1,
8454:8, 8454:19,
8454:32, 8454:40,
8455:38, 8460:17,
8466:47, 8467:12,
8467:14, 8473:13,
8473:32, 8474:16,
8474:26, 8474:44,
8475:9, 8475:37,
8476:24, 8482:19,
8482:39, 8482:40,
8482:41, 8483:5,
8489:4, 8490:20,
8490:21

offending [5] -
8455:27, 8466:45,
8476:10, 8476:16,
8489:22

often [42] - 8444:1,
8445:24, 8447:19,
8447:27, 8447:35,
8449:30, 8449:31,
8449:47, 8451:32,
8455:6, 8457:35,
8458:17, 8458:28,
8459:7, 8459:9,
8460:17, 8463:6,
8463:46, 8465:40,
8465:41, 8466:16,
8466:17, 8466:19,
8466:21, 8467:5,
8471:3, 8471:4,
8472:10, 8472:46,
8473:10, 8473:16,
8473:24, 8473:38,
8473:40, 8474:8,
8474:16, 8479:42,
8482:31, 8483:31,
8483:37, 8489:4

old [4] - 8477:42,
8479:18, 8480:18,
8480:31

older [4] - 8457:27,
8457:29, 8488:23,
8488:33

Olds [2] - 8492:14,
8492:28

once [7] - 8447:40,
8452:26, 8478:9,
8478:10, 8479:40,
8488:32, 8491:27

one [33] - 8443:10,
8443:27, 8444:13,
8446:29, 8446:30,
8452:25, 8455:7,
8455:32, 8457:4,
8457:45, 8458:7,
8458:33, 8461:20,
8461:23, 8465:22,
8471:20, 8471:24,
8471:44, 8472:39,
8473:30, 8476:17,
8477:26, 8477:27,
8478:8, 8482:1,
8483:13, 8491:18,
8492:6, 8493:1,
8494:3, 8494:35,
8494:39, 8495:23

one's [4] - 8454:3,
8472:20, 8483:12,
8494:40

one-off [1] - 8461:20

ones [11] - 8446:1,
8456:14, 8456:15,
8465:18, 8465:26,
8474:45, 8484:24,
8484:46, 8485:3,
8485:5, 8492:20

ongoing [9] - 8461:19,
8461:23, 8461:29,
8462:32, 8465:34,
8469:47, 8470:26,
8483:8, 8493:21

opens [1] - 8494:16

operandi [1] - 8489:7

operates [2] -
8452:40, 8486:35

operating [1] -
8492:27

opinion [2] - 8453:14,
8484:14

opportunistic [1] -
8474:26

opportunities [1] -
8455:41

opportunity [2] -
8459:35, 8474:39

opposed [1] - 8456:30

opposite [2] -
8445:19, 8445:26

option [3] - 8463:8,
8464:35, 8474:34

order [3] - 8462:14,
8475:21, 8476:17

ordinary [2] - 8468:2,
8479:29

organ [2] - 8463:29,
8494:3

organisation [6] -
8453:6, 8453:9,
8455:19, 8473:21,
8473:39, 8485:4

organisational [2] -
8446:40, 8446:45

organisations [13] -
8446:11, 8446:19,
8446:42, 8447:3,
8448:11, 8448:24,
8448:42, 8448:43,
8450:36, 8453:45,
8481:27, 8481:33,
8481:39

organise [1] - 8469:22

organised [1] -
8453:39

organising [1] -
8469:32

orientation [7] -
8453:16, 8455:30,
8465:45, 8473:45,
8474:13, 8475:41,
8475:43

orphanage [2] -
8462:4, 8491:17

orphanage-style [1] -
8491:17

orphanages [3] -
8443:47, 8462:2,
8489:45

orphans [1] - 8462:1

otherwise [4] -
8452:27, 8456:41,
8482:15, 8489:5

ought [5] - 8469:23,
8470:9, 8470:14,
8470:18, 8470:24

out-of-home [10] -
8489:40, 8489:44,
8489:47, 8490:3,
8490:8, 8490:22,
8490:27, 8490:29,
8490:35, 8491:18

outcome [5] -
8450:20, 8450:32,
8458:15, 8465:13

outcomes [2] -
8471:24, 8492:30

outside [2] - 8444:42,
8475:37

overactive [1] -
8477:33

overt [1] - 8477:33

own [8] - 8444:46,
8445:38, 8459:31,
8459:33, 8467:6,
8476:4, 8491:21,
8493:6

P

pace [2] - 8468:28,
8468:29

paedophile [2] -
8473:47, 8474:25

paid [1] - 8481:46

pain [1] - 8467:1

paper [1] - 8447:44

paradigm [1] -
8488:34

paradoxical [1] -
8465:6

parameters [1] -
8446:38

parent [2] - 8491:23,
8492:2

parent-child [1] -
8492:2

parents [9] - 8466:36,
8483:33, 8483:38,
8484:1, 8490:20,
8491:14, 8491:22,
8491:36, 8492:9

parked [1] - 8462:3

parole [1] - 8476:34

part [36] - 8444:30,
8447:28, 8447:29,
8455:10, 8455:20,
8458:26, 8461:26,
8462:38, 8462:43,
8467:45, 8469:46,
8470:6, 8470:14,
8470:17, 8470:18,
8470:22, 8470:24,
8470:27, 8471:3,
8472:27, 8472:28,
8472:30, 8473:26,
8478:20, 8478:32,
8482:34, 8483:41,
8483:44, 8484:14,
8484:15, 8486:3,
8494:1, 8494:5,
8494:8, 8494:44

participant [1] -
8460:33

participate [1] -
8446:12

participated [1] -
8446:16

particular [18] -
8444:13, 8445:36,
8452:23, 8452:24,
8454:17, 8454:38,
8456:42, 8465:11,
8471:39, 8472:9,
8473:8, 8473:34,
8474:19, 8474:36,
8481:7, 8485:3,
8485:35, 8492:13

particularly [13] -
8442:41, 8443:2,
8444:33, 8450:35,
8455:8, 8462:38,
8471:43, 8473:11,
8474:20, 8485:12,
8489:28, 8492:10,
8493:16

partners [1] - 8493:13

past [8] - 8454:31,
8454:33, 8454:34,
8458:47, 8468:33,
8474:37, 8475:9,
8486:16

patches [2] - 8459:10,
8478:23

path [1] - 8495:14

pathogen [3] - 8488:5,
8488:12, 8488:14

pathogenic [1] -
8488:7

pathway [1] - 8470:43

patients [2] - 8443:17,
8443:18

pay [1] - 8482:3

penetration [1] -
8487:37

penetrative [5] -
8450:17, 8450:27,
8456:30, 8456:34,
8456:35

penile [1] - 8454:24

people [95] - 8442:8,
8446:12, 8449:25,
8450:39, 8453:3,
8453:4, 8453:8,
8453:15, 8453:43,
8454:1, 8454:7,
8454:16, 8454:47,
8455:4, 8455:6,
8457:36, 8459:2,
8459:7, 8459:24,
8459:35, 8461:2,
8461:10, 8461:40,
8462:41, 8465:7,
8465:28, 8466:4,
8466:5, 8466:19,
8466:20, 8466:29,
8467:2, 8467:47,
8468:19, 8468:26,
8468:34, 8469:10,
8469:14, 8469:18,
8469:41, 8470:33,
8470:36, 8471:5,
8471:24, 8472:39,
8474:12, 8474:30,
8474:35, 8474:40,
8474:44, 8475:24,
8475:40, 8476:21,

8476:41, 8477:42,
8478:18, 8478:26,
8478:27, 8478:38,
8479:4, 8479:8,
8479:27, 8479:29,
8479:33, 8479:42,
8480:25, 8480:36,
8481:28, 8481:29,
8481:32, 8485:19,
8486:17, 8486:21,
8486:22, 8486:26,
8486:28, 8486:34,
8486:40, 8487:19,
8487:21, 8487:28,
8489:35, 8490:37,
8491:13, 8492:9,
8492:45, 8493:17,
8493:19, 8493:27,
8493:34, 8493:43,
8495:1, 8495:13

people's [1] - 8475:42

per [15] - 8452:4,
8452:6, 8452:16,
8452:17, 8456:3,
8456:13, 8476:21,
8477:14, 8477:17,
8478:3, 8487:19,
8487:21, 8487:34,
8487:37, 8492:20

percentage [1] -
8476:37

perception [1] -
8461:41

perhaps [6] - 8442:17,
8446:8, 8453:32,
8455:15, 8493:40,
8497:1

period [9] - 8456:20,
8461:22, 8461:28,
8462:33, 8465:40,
8465:42, 8472:24,
8492:10, 8492:18

perpetrated [1] -
8484:13

perpetrator [2] -
8459:1, 8488:25

perpetrators [2] -
8448:33, 8487:36

persist [1] - 8457:42

person [28] - 8449:10,
8450:20, 8458:34,
8459:26, 8459:29,
8460:5, 8461:20,
8461:39, 8464:30,
8464:39, 8465:1,
8468:14, 8468:24,
8468:43, 8469:8,
8470:1, 8470:41,
8471:28, 8471:44,
8473:36, 8475:32,
8478:25, 8479:10,
8479:36, 8479:38,
8482:47, 8492:14,
8494:5

person's [8] -
8449:20, 8454:46,
8459:20, 8463:30,
8465:30, 8466:44,
8471:8, 8479:47

personality [3] -
8461:31, 8465:33,
8465:37

perspective [2] -
8459:32, 8494:12

persuaded [1] -
8460:31

pervasive [2] - 8449:9,
8470:9

perverse [2] -
8464:41, 8466:17

Peter [1] - 8441:32

phase [1] - 8461:28

PhD [1] - 8442:33

phenomena [4] -
8458:26, 8458:32,
8461:16, 8480:25

phenomenon [4] -
8460:10, 8461:20,
8465:19, 8465:23

philosopher [1] -
8446:41

philosophy [1] -
8442:38

photographs [1] -
8454:20

physical [18] -
8444:17, 8444:30,
8445:33, 8449:46,
8450:16, 8450:24,
8462:7, 8462:23,
8463:38, 8472:44,
8473:4, 8474:38,
8477:25, 8484:12,
8484:17, 8493:13

physically [4] -
8484:31, 8484:40,
8489:8, 8489:34

picked [1] - 8492:17

picture [1] - 8468:1

pictures [3] - 8454:21,
8462:10, 8462:11

pile [1] - 8456:26

pill [1] - 8465:24

pimps [1] - 8466:20

place [6] - 8444:14,
8450:39, 8453:43,
8462:23, 8478:4,
8486:35

placed [2] - 8490:33,
8491:32

placement [1] -
8491:34

plagued [1] - 8471:14

plain [2] - 8486:12,
8496:13

plaintiffs [1] - 8443:30

play [3] - 8457:33,
8478:18, 8488:29

plenty [1] - 8463:15

point [7] - 8445:16,
8449:22, 8456:27,
8460:35, 8470:34,
8493:5, 8494:42

pointed [1] - 8451:39

Pommie [1] - 8444:32

port [1] - 8480:45

posing [1] - 8494:19

position [8] - 8463:7,
8464:33, 8475:35,
8476:2, 8493:7,
8496:21, 8496:26,
8496:38

positioned [1] -
8465:2

positions [2] -
8464:42, 8496:37

possibility [1] -
8493:2

possible [5] - 8445:6,
8450:3, 8479:27,
8486:4, 8493:43

post [6] - 8457:33,
8457:35, 8457:36,
8457:38, 8457:39,
8458:17

post-traumatic [6] -
8457:33, 8457:35,
8457:36, 8457:38,
8457:39, 8458:17

postgraduate [1] -
8469:9

poverty [2] - 8472:47,
8488:9

power [1] - 8451:2

practice [1] - 8482:17

pre [6] - 8449:6,
8457:11, 8457:26,
8458:27, 8458:39,
8480:21

pre-occupied [3] -
8449:6, 8458:27,
8458:39

pre-school [3] -
8457:11, 8457:26,
8480:21

precise [1] - 8452:23

precocious [1] -
8468:9

predatory [1] -
8457:20

predilection [1] -
8474:36

predisposed [2] -
8477:30, 8477:31

preferable [1] -
8491:19

pregnancy [1] -
8492:16

pregnant [1] - 8466:24

preoccupation [1] -
8471:18

preoccupied [1] -
8458:24

prepared [1] - 8496:14

prescription [1] -
8465:22

presentations [2] -
8446:9, 8465:28

presented [2] -
8446:7, 8447:44

Presiding [1] -
8441:32

pretty [1] - 8488:33

prevalence [1] -
8451:25

prevalent [3] -
8448:30, 8457:37,
8477:26

prevention [2] -
8487:1, 8490:36

previous [1] - 8490:5

priceless [1] - 8490:42

priest [3] - 8455:11,
8471:41, 8474:4

priesthood [2] -
8453:18, 8453:29

priests [2] - 8455:27,
8474:9

primarily [2] -
8443:15, 8443:17

prioritises [1] -
8493:22

prison [19] - 8474:31,
8474:32, 8474:33,
8476:11, 8476:14,
8476:15, 8476:21,
8476:44, 8477:11,
8477:24, 8477:46,
8478:3, 8482:23,
8482:24, 8482:25,
8482:37, 8482:39,
8482:41

prisoners [1] - 8477:9

prisons [9] - 8475:10,
8475:47, 8477:6,
8477:9, 8477:12,
8477:43, 8478:1,
8480:12, 8482:38

private [4] - 8445:19,
8445:22, 8450:4,
8460:4

privation [1] - 8444:18

problem [19] -
8446:14, 8446:32,
8446:35, 8448:11,
8449:33, 8453:4,
8454:31, 8454:35,
8457:12, 8458:41,
8461:2, 8468:39,
8470:10, 8471:13,
8477:41, 8484:45,
8485:6, 8487:26,
8490:20

problems [12] -
8446:33, 8455:7,
8458:17, 8482:1,
8485:1, 8486:37,
8488:8, 8490:5,
8490:10, 8490:17,
8491:11, 8493:22

process [15] - 8444:7,
8445:39, 8447:37,
8447:41, 8448:35,
8448:37, 8455:28,
8459:28, 8460:31,
8469:6, 8469:19,
8483:46, 8484:11,
8493:2, 8493:39

profession [5] -
8453:26, 8453:40,
8469:31, 8482:35,
8485:12

professional [6] -
8460:42, 8469:17,
8469:23, 8469:33,
8469:42, 8469:45

professions [3] -
8460:46, 8461:5,
8481:42

Professor [1] -
8442:26

professor [12] -
8449:40, 8455:6,
8456:19, 8460:1,
8468:38, 8469:16,
8470:20, 8470:31,
8486:1, 8486:45,
8487:46, 8495:27

profile [4] - 8454:38,
8473:30, 8473:34,
8474:19

profound [1] - 8472:4

profoundly [1] -
8472:33

program [15] -
8446:21, 8469:47,
8470:1, 8470:24,
8475:40, 8476:1,
8476:27, 8476:29,
8476:31, 8476:32,

8476:33, 8492:5,
8492:6, 8492:8,
8492:23
programme [2] -
8470:15, 8470:17
programs [8] - 8475:9,
8475:11, 8475:12,
8475:13, 8475:15,
8476:17, 8477:5,
8485:41
progress [2] -
8449:29, 8449:30
project [1] - 8446:38
proliferate [2] -
8480:28, 8480:29
proliferates [1] -
8480:29
prolonged [1] -
8445:37
promote [2] - 8485:45,
8485:46
promoting [1] -
8485:42
prone [2] - 8472:47,
8486:42
properly [1] - 8481:24
proportion [3] -
8457:19, 8466:46,
8467:11
proposed [1] - 8496:1
proposition [1] -
8493:16
prospect [1] - 8475:21
prospects [4] -
8475:39, 8476:40,
8476:41, 8486:47
prostitute [1] -
8466:15
prostitution [3] -
8466:12, 8466:15,
8466:16
protecting [1] -
8479:26
protective [2] -
8489:47, 8490:28
protesting [1] -
8475:30
protracted [1] -
8460:31
prove [1] - 8453:35
provide [5] - 8445:10,
8469:5, 8481:26,
8482:6, 8485:45
provided [2] -
8489:44, 8490:32
provides [1] - 8483:4
providing [2] - 8482:4,
8482:35
provision [1] -
8491:18

psychiatric [15] -
8443:4, 8443:18,
8449:23, 8459:39,
8460:45, 8461:4,
8465:10, 8465:12,
8465:14, 8477:45,
8482:12, 8485:32,
8487:18, 8493:12,
8494:12
psychiatrically [1] -
8454:9
psychiatrist [3] -
8442:28, 8480:19,
8483:9
Psychiatrists [2] -
8442:34, 8447:46
Psychiatry [2] -
8442:26, 8447:45
psychiatry [14] -
8442:35, 8442:36,
8448:21, 8448:22,
8448:26, 8448:28,
8448:32, 8448:44,
8449:4, 8449:6,
8449:11, 8449:35,
8450:28, 8468:32
psychological [21] -
8442:33, 8446:44,
8449:47, 8450:23,
8451:44, 8454:37,
8454:38, 8460:46,
8464:15, 8464:27,
8464:38, 8465:14,
8465:27, 8466:9,
8468:22, 8472:44,
8473:4, 8477:7,
8477:25, 8479:24,
8493:7
psychologically [10] -
8444:26, 8445:39,
8450:6, 8450:8,
8450:34, 8450:40,
8450:46, 8451:21,
8454:8, 8489:8
psychologist [1] -
8481:37
psychologists [2] -
8477:11, 8481:13
psychology [1] -
8461:5
psychometric [1] -
8493:12
psychopathic [2] -
8454:39, 8474:20
psychosexual [1] -
8455:26
psychosexually [1] -
8455:42
psychosis [1] - 8478:5
psychosomatic [1] -

8463:41
psychotherapy [2] -
8442:35, 8443:21
psychotic [2] -
8478:3, 8478:5
PTSD [15] - 8457:40,
8457:46, 8458:13,
8458:14, 8458:21,
8458:26, 8458:32,
8458:44, 8461:8,
8461:9, 8461:10,
8461:15, 8461:30,
8463:18, 8463:31
Public [1] - 8441:16
public [10] - 8460:3,
8487:1, 8487:6,
8487:10, 8487:12,
8487:14, 8487:24,
8487:46, 8488:2,
8489:20
publicity [1] - 8448:41
pull [1] - 8464:38
punish [1] - 8484:40
punished [2] -
8444:38, 8484:31
punishment [3] -
8484:30, 8484:35,
8484:38
purpose [2] - 8445:10,
8445:43
purposes [2] - 8446:4,
8493:39
push [2] - 8464:38,
8468:12
put [16] - 8451:32,
8451:35, 8453:43,
8459:32, 8463:8,
8478:9, 8479:33,
8480:5, 8480:37,
8486:17, 8486:26,
8486:28, 8488:7,
8491:6, 8491:43,
8491:45
puts [1] - 8464:32
putting [3] - 8466:39,
8479:6, 8490:22

Q

QUADRIO [1] -
8442:19
Quadrio [3] - 8442:12,
8442:25, 8471:36
qualification [1] -
8442:32
qualifications [3] -
8442:31, 8468:15,
8480:11
qualified [1] - 8481:24
quality [1] - 8493:19

questions [4] -
8481:22, 8484:43,
8486:46, 8492:38
queues [1] - 8458:43
quick [1] - 8478:43
quite [20] - 8443:13,
8444:8, 8444:14,
8444:15, 8445:19,
8445:26, 8445:31,
8445:39, 8449:4,
8458:43, 8461:46,
8464:31, 8465:44,
8473:14, 8473:38,
8473:40, 8473:43,
8476:20, 8486:19

R

racing [1] - 8458:3
random [2] - 8452:28,
8452:29
range [5] - 8443:3,
8457:6, 8463:45,
8464:15, 8464:21
ranges [1] - 8450:17
rarely [1] - 8461:20
rate [4] - 8476:36,
8476:39, 8476:42,
8491:26
rates [3] - 8476:10,
8476:12, 8492:19
rather [7] - 8449:6,
8449:11, 8449:36,
8474:18, 8477:45,
8489:44, 8491:14
rational [3] - 8450:28,
8481:3, 8481:5
raw [1] - 8491:39
re [2] - 8459:33,
8466:13
re-examine [1] -
8459:33
re-victimised [1] -
8466:13
reacting [1] - 8458:43
reaction [5] - 8458:44,
8473:28, 8475:26,
8475:38, 8480:41
reactions [1] -
8447:36
read [1] - 8458:35
reading [1] - 8458:39
ready [1] - 8466:7
real [5] - 8463:40,
8463:43, 8472:44,
8472:45, 8490:20
realise [7] - 8460:40,
8466:30, 8467:46,
8468:10, 8483:37,
8486:31, 8495:14
realises [2] - 8483:39,
8484:4
reality [2] - 8451:22,
8486:41
really [58] - 8443:43,
8444:8, 8444:10,
8444:38, 8447:17,
8447:20, 8447:41,
8448:28, 8448:44,
8449:13, 8451:13,
8451:33, 8452:22,
8456:14, 8457:9,
8457:17, 8458:23,
8459:18, 8464:36,
8464:42, 8465:20,
8466:37, 8466:40,
8468:31, 8469:23,
8471:42, 8471:46,
8472:12, 8472:34,
8473:14, 8473:22,
8473:26, 8474:12,
8475:32, 8475:41,
8475:43, 8477:27,
8477:46, 8478:10,
8478:20, 8480:30,
8480:31, 8480:34,
8481:29, 8481:32,
8481:38, 8481:40,
8482:36, 8482:38,
8487:1, 8488:47,
8489:3, 8489:15,
8489:29, 8490:6,
8490:43, 8494:6,
8494:17
reason [10] - 8448:39,
8455:13, 8455:28,
8470:42, 8477:28,
8477:30, 8480:6,
8481:2, 8481:15,
8494:40
reasonably [4] -
8454:25, 8456:6,
8462:31, 8474:15
reasons [1] - 8457:6
recalled [3] - 8495:38,
8496:30, 8496:41
recent [1] - 8446:9
reception [1] -
8472:11
recidivism [2] -
8476:39, 8476:42
recognised [1] -
8448:26
recognition [1] -
8470:3
recommendations [1]
- 8486:4
record [1] - 8496:36
recovered [3] -
8478:31, 8478:37,

8478:47
recreational [1] - 8474:18
redress [3] - 8460:41, 8482:2, 8482:11
refer [4] - 8443:23, 8452:15, 8468:14, 8468:16
reference [1] - 8493:30
referred [3] - 8466:29, 8468:40, 8473:7
referring [3] - 8483:45, 8496:5, 8496:11
refund [1] - 8456:47
regard [1] - 8454:41
regressing [1] - 8456:45
regular [4] - 8474:30, 8492:19, 8492:20, 8492:31
rehabilitate [1] - 8490:19
rehabilitation [6] - 8475:21, 8475:32, 8475:39, 8475:40, 8476:18, 8478:2
relate [2] - 8444:44, 8480:3
relation [7] - 8443:6, 8446:8, 8449:5, 8452:14, 8476:10, 8496:21, 8496:26
relationship [9] - 8450:5, 8460:32, 8466:3, 8470:43, 8470:45, 8470:46, 8474:47, 8475:1, 8480:3
relationships [12] - 8443:19, 8444:42, 8444:43, 8449:28, 8465:38, 8467:6, 8474:1, 8474:2, 8474:9, 8474:31, 8476:8, 8494:39
relatively [1] - 8445:31
released [1] - 8476:37
relevant [2] - 8456:21, 8456:23
reliable [2] - 8451:47, 8454:25
reliably [1] - 8452:4
reliance [1] - 8465:22
religion [1] - 8472:9
religions [1] - 8474:9
religious [11] - 8446:11, 8448:11, 8448:24, 8450:36, 8450:47, 8451:26, 8453:9, 8453:45, 8471:40, 8475:20, 8486:15
relying [1] - 8449:37
remain [1] - 8470:29
remarkably [1] - 8456:24
remember [4] - 8458:46, 8459:12, 8472:16, 8479:20
remembering [2] - 8478:22, 8478:23
remorse [1] - 8475:23
remove [2] - 8491:2, 8491:22
removed [5] - 8490:17, 8490:18, 8490:27, 8491:32, 8491:40
removing [1] - 8490:22
render [1] - 8493:8
repair [1] - 8490:13
report [3] - 8445:11, 8493:9, 8493:20
reportage [1] - 8495:4
reported [5] - 8446:33, 8468:39, 8468:44, 8489:22, 8492:44
reports [4] - 8445:13, 8458:35, 8460:7, 8493:20
represent [2] - 8492:43, 8495:35
representation [1] - 8469:27
repressed [3] - 8478:18, 8478:31, 8479:23
repression [1] - 8479:27
reputation [1] - 8482:26
requirement [1] - 8470:26
research [15] - 8443:15, 8446:21, 8446:38, 8448:46, 8448:47, 8449:1, 8451:24, 8452:32, 8454:12, 8467:26, 8467:31, 8477:16, 8482:12, 8482:18, 8487:38
researched [1] - 8485:37
researcher [1] - 8454:17
resident [2] - 8491:6, 8491:8
resilience [12] - 8456:19, 8456:22, 8485:8, 8485:10, 8485:11, 8485:23, 8485:37, 8485:40, 8485:42, 8485:43, 8485:45, 8485:46
resilient [5] - 8456:5, 8456:15, 8456:25, 8456:40, 8485:41
resist [1] - 8467:44
resorting [1] - 8458:16
resources [3] - 8480:12, 8491:43, 8491:45
respect [2] - 8484:10, 8487:1
respected [4] - 8453:25, 8473:20, 8473:40, 8473:43
respects [1] - 8487:6
respond [1] - 8466:30
responding [1] - 8484:43
response [1] - 8472:12
RESPONSES [1] - 8441:12
responses [4] - 8454:21, 8454:22, 8454:24, 8454:25
responsibility [4] - 8469:18, 8476:2, 8476:4, 8476:26
responsive [1] - 8455:38
rest [1] - 8462:33
result [1] - 8461:11
results [2] - 8459:6, 8482:13
retarded [2] - 8462:6, 8462:7
retreat [1] - 8463:27
retribution [1] - 8489:33
revved [4] - 8457:44, 8458:22, 8459:26, 8463:33
rid [2] - 8459:36, 8478:25
Ridsdale [4] - 8496:22, 8496:27, 8496:29, 8496:41
rigid [1] - 8453:10
rigor [1] - 8494:31
ripples [1] - 8493:36
risk [6] - 8486:8, 8486:10, 8487:10, 8491:28, 8491:36, 8491:37
role [2] - 8442:47, 8478:18
roll [1] - 8446:21
Romania [1] - 8462:2
Romanian [1] - 8462:1
rough [1] - 8494:29
roughly [2] - 8494:25, 8494:33
routine [1] - 8469:25
Royal [8] - 8442:23, 8442:30, 8442:34, 8460:1, 8460:40, 8469:1, 8486:46, 8489:46
ROYAL [1] - 8441:11
rules [1] - 8474:21
run [3] - 8464:34, 8464:35, 8482:12
running [4] - 8458:40, 8486:27, 8492:5
rural [1] - 8445:24

S

sad [10] - 8456:44, 8464:17, 8467:5, 8477:26, 8477:36, 8477:44, 8477:46, 8478:8, 8480:34, 8491:21
sadistic [2] - 8444:17, 8489:36
safe [3] - 8468:27, 8487:8, 8490:11
sake [1] - 8472:22
sample [1] - 8443:32
sat [1] - 8479:17
saw [3] - 8445:16, 8445:17, 8484:38
scared [2] - 8456:44, 8477:36
scenario [1] - 8480:17
schizophrenia [1] - 8487:40
school [16] - 8445:19, 8445:22, 8445:25, 8445:26, 8445:27, 8449:28, 8450:4, 8456:46, 8456:47, 8457:11, 8457:26, 8458:2, 8464:18, 8473:21, 8480:21
School [1] - 8442:26
schools [3] - 8484:27, 8484:39
scientific [1] - 8494:31
scouts [1] - 8479:19
screen [2] - 8453:43, 8454:1
screening [14] - 8453:42, 8453:44, 8453:47, 8454:13, 8454:19, 8454:30, 8454:46, 8454:47, 8486:34, 8490:2, 8490:6, 8490:30, 8490:31
scrupulous [2] - 8490:2, 8490:6
scrutiny [1] - 8486:43
second [2] - 8488:19, 8493:30
secondarily [1] - 8458:16
secondly [1] - 8442:12
secrecy [1] - 8447:32
secret [1] - 8445:3
secure [4] - 8486:23, 8486:25, 8487:7, 8494:37
security [3] - 8444:3, 8486:20, 8486:29
seduction [1] - 8451:12
see [29] - 8445:8, 8446:28, 8462:9, 8462:10, 8462:37, 8463:36, 8463:37, 8463:39, 8465:20, 8466:33, 8469:12, 8471:41, 8473:14, 8474:11, 8477:42, 8479:3, 8480:2, 8480:17, 8480:19, 8480:45, 8481:24, 8481:37, 8481:45, 8482:42, 8483:13, 8485:39, 8492:10
seeing [4] - 8459:1, 8469:9, 8478:19, 8482:37
seek [4] - 8453:22, 8453:23, 8466:38, 8474:40
seeking [2] - 8493:17, 8493:40
seem [6] - 8456:25, 8466:35, 8472:24, 8472:32, 8477:30, 8494:37
selected [1] - 8476:40
self [8] - 8459:34, 8460:20, 8461:41, 8461:43, 8471:26, 8481:40, 8483:41, 8493:9
self-blame [2] - 8460:20, 8471:26

self-doubt [1] - 8448:33, 8449:47, 8459:34
self-help [1] - 8481:40
self-perception [1] - 8461:41
self-report [1] - 8493:9
sense [18] - 8450:3, 8450:36, 8451:3, 8453:36, 8459:28, 8459:40, 8459:44, 8460:20, 8460:35, 8460:37, 8461:39, 8461:40, 8461:43, 8471:43, 8472:21, 8472:33, 8475:23, 8476:5
sent [2] - 8444:13, 8445:25
separate [4] - 8482:15, 8483:6, 8484:42, 8494:6
sequelae [1] - 8493:45
sequence [1] - 8461:26
serious [2] - 8451:13, 8463:38
seriously [1] - 8448:45
service [4] - 8469:39, 8481:26, 8482:35, 8492:2
services [8] - 8468:17, 8477:8, 8477:45, 8478:2, 8490:38, 8490:42, 8492:2
sessions [1] - 8460:4
set [2] - 8477:43, 8477:45
setting [1] - 8491:32
seven [3] - 8445:18, 8445:21, 8445:22
severe [4] - 8444:18, 8464:7, 8471:2
severity [1] - 8464:6
sex [16] - 8450:17, 8453:17, 8453:20, 8454:1, 8456:34, 8465:42, 8466:5, 8466:22, 8466:24, 8474:32, 8474:33, 8474:41, 8475:41, 8476:23, 8482:38, 8482:39
sexual [71] - 8443:2, 8443:6, 8443:17, 8444:20, 8444:28, 8444:37, 8445:31, 8445:34, 8446:11, 8447:46, 8448:10, 8448:33, 8449:47, 8450:5, 8450:10, 8450:12, 8450:13, 8450:26, 8450:27, 8451:17, 8451:25, 8451:39, 8452:5, 8453:33, 8454:44, 8454:46, 8455:31, 8456:30, 8457:4, 8457:20, 8457:21, 8457:34, 8458:12, 8458:35, 8465:13, 8465:38, 8465:39, 8466:3, 8466:8, 8466:9, 8466:44, 8467:16, 8467:18, 8467:22, 8468:2, 8468:3, 8468:5, 8468:9, 8473:31, 8473:36, 8473:45, 8474:31, 8475:4, 8475:42, 8477:20, 8477:25, 8484:13, 8487:2, 8488:2, 8488:20, 8488:29, 8489:6, 8489:9, 8489:37, 8493:46, 8494:47, 8495:18
SEXUAL [1] - 8441:12
sexualised [3] - 8457:14, 8457:18, 8457:25
sexuality [3] - 8465:41, 8466:43, 8466:44
sexually [17] - 8443:24, 8450:7, 8453:36, 8454:16, 8455:33, 8457:19, 8466:5, 8466:6, 8466:25, 8467:13, 8467:15, 8467:21, 8472:41, 8477:9, 8478:19, 8489:11, 8491:31
shame [12] - 8459:34, 8459:36, 8459:40, 8460:20, 8460:36, 8460:38, 8461:2, 8461:42, 8471:26, 8480:23, 8483:22, 8483:41
shattered [1] - 8494:20
shattering [2] - 8471:43, 8471:46
shatters [1] - 8472:20
sheer [1] - 8443:11
shelter [1] - 8462:16
shift [2] - 8448:27, 8459:45
shock [1] - 8479:38
shocked [1] - 8479:41
shocking [1] - 8461:13
SHORT [1] - 8471:34
short [4] - 8455:46, 8456:39, 8471:31, 8471:32
short-term [2] - 8455:46, 8456:39
shorter [5] - 8442:15, 8463:47, 8464:13, 8464:14
shot [1] - 8467:12
shoulder [1] - 8492:33
show [14] - 8454:8, 8456:4, 8456:31, 8456:43, 8457:8, 8457:25, 8457:26, 8462:30, 8463:16, 8463:21, 8464:16, 8465:36, 8477:33, 8492:30
showed [1] - 8444:37
showing [2] - 8463:42, 8466:33
shows [2] - 8456:21, 8457:20
shrunk [1] - 8462:9
shut [1] - 8486:38
sibling [1] - 8457:8
siblings [5] - 8493:14, 8494:23, 8494:24, 8494:32, 8494:33
side [3] - 8472:40, 8482:26, 8483:13
sign [1] - 8457:21
significant [11] - 8452:29, 8452:35, 8452:39, 8454:41, 8464:32, 8476:39, 8476:41, 8486:3, 8487:34, 8490:34, 8491:29
significantly [1] - 8479:35
signs [1] - 8444:37
similar [12] - 8446:29, 8446:30, 8472:17, 8476:15, 8476:38, 8477:5, 8481:26, 8488:36, 8488:37, 8494:34, 8494:35
similarly [1] - 8458:31
simple [2] - 8461:15, 8492:31
single [7] - 8444:1, 8444:3, 8444:34, 8449:9, 8455:32, 8488:5, 8492:18
sisters [1] - 8494:26
sit [2] - 8479:12, 8480:19
situation [12] - 8452:29, 8464:36, 8464:37, 8464:38, 8465:4, 8465:7, 8465:34, 8466:1, 8471:21, 8474:34, 8479:10, 8482:37
situational [1] - 8455:37
situations [2] - 8453:22, 8453:23
skewed [2] - 8482:14, 8482:15
skills [1] - 8480:11
sleep [2] - 8456:44, 8459:6
sleeper [3] - 8456:9, 8456:41, 8472:16
sleepers [1] - 8466:29
sleeping [2] - 8458:5, 8464:17
slow [2] - 8448:35, 8448:37
slowly [1] - 8459:31
small [2] - 8458:9, 8466:46
smaller [2] - 8462:11, 8489:13
soak [1] - 8463:5
soaks [1] - 8463:5
social [2] - 8444:2, 8462:18
socially [1] - 8474:17
society [2] - 8477:28, 8478:9
sociopathy [1] - 8454:39
solid [1] - 8495:11
solution [1] - 8490:23
somatic [1] - 8463:42
someone [15] - 8458:44, 8459:1, 8464:28, 8464:31, 8464:33, 8464:44, 8464:46, 8475:21, 8475:43, 8478:4, 8478:11, 8481:45, 8481:46, 8494:46, 8495:12
something's [2] - 8479:11, 8480:30
sometimes [26] - 8451:11, 8459:2, 8459:10, 8461:15, 8465:29, 8466:7, 8471:13, 8471:19, 8473:12, 8473:46, 8474:3, 8474:35, 8474:44, 8479:38, 8479:41, 8479:46, 8481:17, 8482:31, 8484:32, 8485:28, 8489:25, 8489:26, 8489:27, 8490:18, 8494:24, 8495:17
somewhere [1] - 8480:37
soothing [1] - 8464:45
sorry [4] - 8445:21, 8474:7, 8496:7, 8496:24
sort [16] - 8450:16, 8451:9, 8457:1, 8462:37, 8464:16, 8467:23, 8469:6, 8469:39, 8469:44, 8474:46, 8477:26, 8477:37, 8484:8, 8485:43, 8487:28, 8491:37
sorts [1] - 8485:27
sound [1] - 8445:31
source [1] - 8467:1
South [9] - 8441:21, 8442:27, 8475:11, 8475:15, 8475:47, 8491:9, 8492:23, 8492:27, 8492:28
speakers [1] - 8446:19
speaking [1] - 8482:18
special [4] - 8451:11, 8451:12, 8460:32
specific [10] - 8457:4, 8457:15, 8459:19, 8459:20, 8464:22, 8464:23, 8468:20, 8471:36, 8493:45
specified [1] - 8469:35
spectrum [1] - 8485:21
spent [1] - 8479:39
spirituality [2] - 8471:38, 8472:18
spiritually [1] - 8450:8
spoken [7] - 8447:40, 8466:43, 8474:25, 8480:9, 8480:11, 8482:18, 8483:19
sponge [1] - 8463:4
sports [1] - 8451:8
spot [1] - 8457:29
spouse [1] - 8447:30
stable [2] - 8494:37,

8494:38
stage [3] - 8447:35, 8448:17, 8485:13
stand [1] - 8471:14
standard [3] - 8484:39, 8484:40
start [1] - 8479:40
started [1] - 8492:16
starting [4] - 8456:44, 8456:47, 8470:34, 8480:36
starts [1] - 8457:7
state [1] - 8463:31
States [1] - 8452:42
statistics [2] - 8452:7, 8491:40
status [1] - 8453:40
stay [2] - 8463:8, 8480:2
sticks [1] - 8478:10
still [12] - 8447:34, 8447:35, 8448:14, 8449:6, 8452:29, 8462:35, 8467:41, 8472:20, 8474:10, 8485:27, 8490:34, 8492:27
stimulated [2] - 8462:17, 8466:6
stimulation [3] - 8462:5, 8462:18, 8468:9
stop [3] - 8476:3, 8480:6, 8481:6
stopped [1] - 8445:7
stops [1] - 8480:30
straight [1] - 8482:13
strange [2] - 8459:14, 8478:21
stranger [1] - 8452:10
strangers [1] - 8491:24
street [1] - 8458:46
Street [1] - 8441:21
stress [3] - 8457:33, 8457:36, 8457:39
strict [1] - 8453:7
strictly [2] - 8445:34, 8453:8
strong [4] - 8470:45, 8470:46, 8477:38, 8485:24
strongly [1] - 8472:8
structure [1] - 8453:39
struggled [2] - 8444:43, 8444:44
struggling [1] - 8491:44
studied [2] - 8452:36, 8452:38
studies [8] - 8445:46, 8452:2, 8452:20, 8452:41, 8452:45, 8462:29, 8463:15, 8492:29
study [8] - 8443:23, 8443:26, 8443:27, 8445:15, 8446:44, 8492:12, 8492:14, 8492:29
Study [1] - 8441:16
style [1] - 8491:17
subject [4] - 8451:29, 8451:31, 8473:12, 8494:46
subjected [3] - 8447:22, 8450:2, 8462:32
submitted [1] - 8445:13
subsequent [1] - 8472:32
subsequently [1] - 8471:37
substance [10] - 8449:32, 8449:36, 8465:19, 8465:25, 8471:4, 8472:47, 8474:15, 8474:17, 8489:2, 8489:4
substances [2] - 8449:37, 8458:16
substantial [1] - 8455:44
success [3] - 8476:10, 8476:12, 8476:36
successful [1] - 8475:18
suddenly [6] - 8464:19, 8464:20, 8464:21, 8472:30, 8472:32, 8478:40
suffer [2] - 8452:5, 8463:18
suffered [2] - 8458:12, 8486:16
suffering [1] - 8457:47
sufficient [1] - 8480:10
sufficiently [1] - 8492:12
suggest [1] - 8470:5
suggested [1] - 8478:41
suggestion [1] - 8469:16
suggestions [1] - 8486:6
suicidal [2] - 8444:47, 8472:38
suicide [7] - 8470:32, 8470:37, 8470:43, 8470:44, 8470:46, 8471:20, 8471:25
suicides [1] - 8472:38
supervising [1] - 8443:1
supervisor [2] - 8442:43, 8442:47
support [5] - 8462:23, 8480:13, 8481:28, 8481:40, 8481:41
supportive [1] - 8483:38
supposed [6] - 8461:38, 8463:4, 8475:33, 8479:24, 8491:3
suppressed [3] - 8478:31, 8479:4, 8479:9
suppression [2] - 8479:21, 8479:28
surprising [1] - 8462:39
survive [3] - 8456:6, 8456:26, 8456:37
survivor [5] - 8448:42, 8448:43, 8468:4, 8481:27, 8481:33
Survivors [1] - 8447:5
survivors [17] - 8446:18, 8449:5, 8449:13, 8449:37, 8468:40, 8469:3, 8469:4, 8480:14, 8481:23, 8481:26, 8481:29, 8481:34, 8481:36, 8481:39, 8481:44, 8483:3, 8494:43
suspect [1] - 8442:8
sustained [2] - 8463:7, 8463:21
sustaining [1] - 8466:22
switched [2] - 8459:24, 8466:5
sworn [2] - 8442:17, 8442:19
Sydney [5] - 8442:44, 8446:10, 8484:44, 8492:3, 8492:6
sympathetic [1] - 8486:40
sympathy [1] - 8478:11
symptom [2] - 8457:45, 8458:7
symptomatic [5] - 8456:8, 8480:40, 8481:2, 8481:6
symptomatically [1] - 8449:15
symptoms [26] - 8449:38, 8450:20, 8456:4, 8456:47, 8457:5, 8457:8, 8457:35, 8457:38, 8457:41, 8458:14, 8458:17, 8459:21, 8461:32, 8463:42, 8464:15, 8466:34, 8471:14, 8471:15, 8471:17, 8471:18, 8480:15, 8480:47, 8481:7
syndrome [2] - 8456:42, 8487:27
system [6] - 8463:39, 8476:15, 8476:44, 8481:23, 8484:4, 8493:18
systematic [7] - 8444:15, 8445:40, 8447:46, 8448:10, 8452:26, 8452:28
systems [1] - 8486:38

T

tantrums [2] - 8464:17, 8477:34
Tardun [1] - 8444:25
teachers [5] - 8443:25, 8451:7, 8454:33, 8481:10, 8481:12
teaching [3] - 8442:43, 8442:44, 8442:47
teams [1] - 8443:1
tears [1] - 8464:19
techniques [1] - 8468:22
teen [1] - 8492:17
teenager [1] - 8466:12
teenagers [1] - 8466:24
temper [2] - 8464:17, 8477:34
temporary [1] - 8491:3
tend [10] - 8443:10, 8449:23, 8450:26, 8453:9, 8465:20, 8465:23, 8474:12, 8475:2, 8480:18, 8494:34
tendency [3] - 8460:13, 8481:4, 8491:2
tends [1] - 8477:38
tens [1] - 8489:39
term [6] - 8455:46, 8456:39, 8464:14, 8465:9, 8465:12
terms [10] - 8449:27, 8455:25, 8467:34, 8469:27, 8473:4, 8474:25, 8476:47, 8483:20, 8483:27, 8488:44
terrible [1] - 8466:11
terribly [2] - 8466:20, 8475:19
tertiary [1] - 8455:15
test [1] - 8454:27
testing [3] - 8454:11, 8486:41, 8493:12
tests [1] - 8462:8
THE [28] - 8442:1, 8442:6, 8449:40, 8455:6, 8456:19, 8462:22, 8464:3, 8469:16, 8470:20, 8470:31, 8471:31, 8486:1, 8492:38, 8495:23, 8495:27, 8495:30, 8495:42, 8496:1, 8496:7, 8496:13, 8496:19, 8496:24, 8496:29, 8496:34, 8496:41, 8496:46, 8497:4, 8497:6
theirs [1] - 8474:36
themselves [1] - 8472:34
themselves [17] - 8453:35, 8455:41, 8459:41, 8460:6, 8460:37, 8467:1, 8467:20, 8468:42, 8473:19, 8473:22, 8473:26, 8474:23, 8476:26, 8479:41, 8487:36, 8493:34, 8494:45
theory [2] - 8480:42, 8480:43
therapist [1] - 8478:41
therapy [4] - 8443:21, 8460:42, 8468:32, 8469:2
there'd [1] - 8448:8
therefore [1] - 8470:2
they've [18] - 8447:22, 8447:27, 8449:36, 8455:40, 8457:41, 8460:36, 8464:31, 8466:30, 8466:34, 8475:22, 8475:33,

8476:5, 8476:22,
8479:14, 8483:38,
8484:47, 8494:38
thing's [1] - 8467:8
thinking [5] - 8455:1,
8460:23, 8461:35,
8479:30, 8479:40
thinks [1] - 8480:30
third [1] - 8494:42
thorough [1] -
8468:18
thoroughly [1] -
8468:45
thoughts [3] - 8458:3,
8471:8, 8486:5
thousands [2] -
8489:21, 8489:40
three [5] - 8444:23,
8446:1, 8488:28,
8488:33, 8494:37
throughout [1] -
8473:7
throw [1] - 8478:13
thrown [1] - 8478:12
tick [2] - 8454:5,
8454:7
Timothy [1] - 8495:36
TO [2] - 8441:12,
8497:7
today [6] - 8442:13,
8442:15, 8447:34,
8489:40, 8495:45
together [4] - 8449:47,
8459:15, 8480:5,
8488:8
tomorrow [2] -
8442:14, 8497:1
took [1] - 8484:46
top [2] - 8472:46,
8473:1
topic [2] - 8447:12,
8470:34
tormented [2] -
8471:19, 8478:27
totally [3] - 8476:18,
8479:46, 8496:13
touched [1] - 8456:33
touching [4] -
8450:17, 8450:28,
8451:18, 8456:30
towards [6] - 8455:30,
8458:40, 8474:13,
8475:41, 8489:34,
8489:43
town [2] - 8444:14,
8481:35
trainees [1] - 8443:2
training [11] -
8455:10, 8455:14,
8455:29, 8469:34,
8469:42, 8470:7,
8470:14, 8470:17,
8470:22, 8470:24,
8483:12
traits [1] - 8454:39
trajectories [1] -
8494:34
trajectories [1] -
8482:43
transmission [3] -
8487:32, 8487:33
transmitted [1] -
8466:25
transparency [1] -
8486:35
trauma [66] - 8443:2,
8443:3, 8443:6,
8444:27, 8447:22,
8449:8, 8449:13,
8449:16, 8449:37,
8456:6, 8456:27,
8458:25, 8458:27,
8459:18, 8461:3,
8461:12, 8461:23,
8461:29, 8461:30,
8463:18, 8463:21,
8465:35, 8466:10,
8467:19, 8467:37,
8468:4, 8468:7,
8468:14, 8468:16,
8468:17, 8468:18,
8468:23, 8468:35,
8468:44, 8469:10,
8469:34, 8469:39,
8469:44, 8471:3,
8472:43, 8477:11,
8477:13, 8477:21,
8478:6, 8478:12,
8478:15, 8478:20,
8478:21, 8478:33,
8478:35, 8480:10,
8481:21, 8482:38,
8482:43, 8487:12,
8487:17, 8487:21,
8487:33, 8488:46,
8489:2, 8490:41,
8494:8, 8494:23,
8495:13
trauma-informed [8] -
8468:16, 8468:17,
8468:23, 8468:35,
8468:44, 8469:39,
8480:10, 8481:21
traumatic [12] -
8447:37, 8447:39,
8456:34, 8457:33,
8457:35, 8457:36,
8457:38, 8457:39,
8458:17, 8459:7,
8464:26, 8477:24
traumatised [7] -
8462:40, 8468:27,
8469:10, 8471:6,
8472:43, 8473:3,
8493:47
traumatising [1] -
8468:25
treat [3] - 8449:37,
8459:22, 8486:24
treated [4] - 8449:36,
8460:21, 8460:22,
8491:7
treating [5] - 8459:29,
8469:10, 8478:4,
8490:21, 8490:42
treatment [26] -
8443:18, 8443:19,
8449:7, 8449:12,
8459:17, 8459:18,
8459:19, 8459:20,
8459:25, 8459:28,
8466:31, 8468:20,
8468:25, 8468:35,
8475:9, 8475:46,
8476:26, 8476:29,
8476:31, 8477:1,
8478:2, 8478:39,
8482:4, 8491:5,
8491:6
treatments [3] -
8468:33, 8480:28,
8481:19
tremendous [1] -
8444:47
trend [1] - 8489:43
triage [3] - 8493:2,
8493:18, 8493:20
tried [2] - 8446:21,
8454:18
trigger [2] - 8458:44,
8479:11
triggered [2] -
8456:16, 8470:41
triggers [5] - 8456:10,
8458:38, 8459:2,
8459:3, 8472:26
trouble [2] - 8447:18,
8473:22
troubled [5] - 8453:33,
8479:47, 8480:17,
8481:14, 8481:15
troubleshooter [1] -
8492:32
troubling [1] -
8459:21
true [9] - 8472:11,
8473:28, 8473:47,
8474:3, 8474:5,
8474:7, 8474:25,
8475:37, 8476:23
trust [4] - 8450:40,
8459:28, 8468:27,
8472:2
try [5] - 8454:15,
8459:32, 8486:13,
8490:13, 8493:40
trying [4] - 8466:40,
8476:1, 8476:4,
8491:13
TUESDAY [1] - 8497:7
turmoil [1] - 8459:26
turn [6] - 8449:31,
8455:45, 8465:9,
8471:6, 8474:46,
8480:32
turned [1] - 8445:5
turns [1] - 8455:2
two [4] - 8446:1,
8462:44, 8492:43,
8494:43
type [2] - 8455:32,
8493:18

U

ulcerative [1] -
8463:44
ultimately [1] -
8455:11
unable [1] - 8456:44
unaffected [1] -
8494:23
under [7] - 8451:2,
8456:16, 8464:23,
8464:42, 8484:19,
8487:14, 8487:41
underlying [1] -
8480:47
understood [4] -
8461:6, 8485:10,
8485:12, 8485:16
undertake [1] -
8469:41
undertaken [1] -
8467:27
unemployment [2] -
8444:41, 8473:1
unfortunately [1] -
8465:27
unhappiness [1] -
8457:2
unhappy [1] - 8457:10
unhealthy [1] -
8472:46
unique [1] - 8460:5
unit [2] - 8491:6,
8492:3
United [1] - 8452:42
units [3] - 8491:5,
8491:9, 8491:47

U

University [1] -
8442:26
university [1] -
8494:26
unknowable [1] -
8494:22
unless [1] - 8494:22
unrelated [2] -
8493:30, 8494:42
unsatisfactory [1] -
8468:46
unusual [9] - 8489:1,
8489:5, 8489:16,
8489:19, 8495:6,
8495:8, 8495:9,
8495:10
unwilling [1] - 8467:6
up [33] - 8456:31,
8457:31, 8457:44,
8458:22, 8459:26,
8460:11, 8460:29,
8461:29, 8463:5,
8463:21, 8463:47,
8467:19, 8469:45,
8470:2, 8470:36,
8471:9, 8472:2,
8473:2, 8477:46,
8478:12, 8479:45,
8479:46, 8480:1,
8481:18, 8482:13,
8483:18, 8486:14,
8486:38, 8487:34,
8489:31, 8491:24,
8494:16
up-to-date [1] -
8470:2
upbringing [1] -
8485:24
upset [4] - 8464:16,
8464:45, 8465:21,
8477:32
useful [2] - 8445:29,
8494:11
useless [1] - 8471:10
usual [5] - 8442:15,
8453:34, 8474:30,
8475:26, 8475:37

V

value [1] - 8451:42
values [1] - 8455:22
varies [1] - 8478:26
variety [5] - 8464:24,
8468:21, 8471:2,
8489:32
various [4] - 8452:21,
8452:22, 8483:21,
8493:31
verbal [1] - 8444:31
verbally [1] - 8489:8

version [1] - 8463:19
vicissitudes [1] - 8493:44
victim [8] - 8475:31, 8475:38, 8476:3, 8476:6, 8478:46, 8488:23, 8488:25, 8494:17
victim's [4] - 8475:28, 8475:29
victimised [1] - 8466:13
victims [14] - 8447:36, 8448:14, 8448:16, 8448:17, 8449:5, 8460:2, 8460:10, 8468:39, 8469:3, 8469:4, 8475:28, 8478:44, 8482:27, 8489:21
Victoria [1] - 8441:22
view [6] - 8445:16, 8471:38, 8483:44, 8484:46, 8485:11, 8489:28
vilification [1] - 8475:28
vilifying [1] - 8475:31
violence [7] - 8456:36, 8487:11, 8487:17, 8487:35, 8487:36, 8488:9
violent [2] - 8461:13, 8488:28
visit [3] - 8473:25, 8492:16, 8492:19
visited [1] - 8492:9
visitor [2] - 8484:7, 8492:21
visitors [1] - 8492:15
visits [1] - 8492:32
visual [1] - 8459:8
voices [1] - 8486:39
volume [1] - 8462:42
voluntarily [2] - 8443:43, 8455:1
volunteer [1] - 8454:3
vow [1] - 8453:19
vulnerable [6] - 8444:12, 8451:32, 8486:32, 8486:33, 8490:9, 8492:17

W

WA [2] - 8443:29, 8444:13
waiting [1] - 8491:14
wake [1] - 8471:9
Wales [8] - 8442:27, 8475:11, 8475:15, 8475:47, 8491:9, 8492:24, 8492:27, 8492:28
walk [2] - 8458:36, 8458:46
WAS [1] - 8497:6
watch [1] - 8458:34
watching [3] - 8458:23, 8458:45, 8466:36
water [2] - 8462:15, 8462:19
watered [1] - 8462:4
ways [12] - 8449:26, 8456:44, 8457:16, 8459:3, 8462:35, 8474:21, 8476:7, 8480:1, 8480:2, 8480:5, 8487:43
week [1] - 8492:44
well-known [4] - 8446:34, 8448:4, 8448:10, 8465:4
Western [2] - 8445:40, 8460:27
wet [1] - 8456:45
whatever" [1] - 8475:30
whatsoever [1] - 8478:38
whereas [5] - 8449:7, 8449:23, 8457:10, 8457:28, 8467:20
whereby [1] - 8493:3
whole [16] - 8444:7, 8447:41, 8458:24, 8459:10, 8463:45, 8464:15, 8464:21, 8466:26, 8467:8, 8472:28, 8472:29, 8476:19, 8478:41, 8481:1, 8485:21, 8490:8
wide [3] - 8457:6, 8460:2, 8464:24
widely [3] - 8446:33, 8448:5, 8484:30
wider [2] - 8455:21, 8455:22
widespread [1] - 8488:15
willing [8] - 8460:33, 8475:22, 8475:33, 8476:20, 8478:46, 8483:40, 8495:38, 8495:40
wish [1] - 8496:41
wished [2] - 8446:39, 8488:19
withdrawing [1] - 8477:36
withdrawn [2] - 8464:17, 8477:37
WITHDREW [1] - 8495:30
witness [5] - 8442:13, 8442:17, 8461:13, 8495:37
Witness [2] - 8477:18, 8489:41
WITNESS [1] - 8495:30
witnesses [1] - 8495:45
woman [2] - 8489:11, 8491:1
women [13] - 8442:41, 8443:23, 8488:47, 8489:3, 8489:4, 8489:6, 8489:7, 8489:22, 8489:25, 8489:31, 8492:17
wonderful [2] - 8481:41, 8491:39
wondering [1] - 8482:29
word [4] - 8443:45, 8449:40, 8449:41, 8450:3
work's [1] - 8448:47
workers [1] - 8490:38
workshops [1] - 8446:7
world [3] - 8448:12, 8461:40, 8466:10
world's [1] - 8450:38
worry [2] - 8454:39, 8486:29
worrying [1] - 8483:24
worst [1] - 8490:39
worthless [1] - 8451:42
wound [1] - 8492:4
written [1] - 8460:3

Y

year [5] - 8469:37, 8470:27, 8490:40, 8492:14, 8492:18
years [22] - 8447:27, 8447:28, 8447:31, 8449:1, 8456:10, 8462:2, 8463:47, 8472:24, 8472:31, 8472:32, 8473:2, 8475:10, 8477:42, 8479:15, 8479:18, 8480:18, 8480:25, 8480:31, 8488:28, 8488:33
young [13] - 8450:38, 8453:28, 8453:32, 8453:38, 8455:9, 8463:3, 8463:6, 8465:39, 8466:11, 8466:21, 8466:23, 8471:41, 8492:17
younger [2] - 8457:8, 8463:1
yourself [7] - 8458:47, 8467:41, 8471:29, 8472:35, 8475:35, 8479:26, 8495:15

Z

Zealand [1] - 8442:34