

Royal Commission into Institutional Responses to Child Sexual Abuse

Issues Paper 10

Advocacy and Support and Therapeutic Treatment Services

Submission from Gatehouse Centre (for the Assessment and Treatment of Child Abuse)

Royal Children's Hospital, Melbourne.

Gatehouse Centre

The Royal Children's Hospital welcomes the opportunity to respond to the Issues Paper regarding advocacy, support and therapeutic treatment services for children and young people who have experienced child sexual abuse and/or engage in sexually harmful behaviour.

The Gatehouse Centre is a department of the Royal Children's Hospital in Melbourne. We provide counselling, advocacy and 24 hour Crisis Care to children and young people who have experienced sexual abuse, either as victims, as children displaying problematic sexualised behaviour or as young people engaging in sexually abusive behaviour.

Case studies at the end of this submission provide examples of cases where advocacy, support and therapeutic services have both been successful and constrained by a range of factors.

Topic A: Victim/survivor needs and unmet needs

1. Qualities of a Service:

A responsive service that can meet the needs of victim/survivors has the following qualities:

- Available for all
- Honest and reliable
- Free of cost (\$)
- Accessible
- Professional (trained/supervised staff)

- Evidence based and incorporating a systems and holistic approach that recognises the significance of developmental theory and trauma informed practice
- Respectful of all clients and their families
- Collaborative with clients, families and agencies
- Non-judgemental of all in the Centre
- Creative so various approaches can be provided
- Flexible funding model to allow for this creativity
- Child and young people centred and family focused
- Allows children to return for counselling at each developmental age and stage.
- No Waiting List

Centres Against Sexual Assault services (CASA) in Victoria aim to achieve the prescribed Standards of Practice for all CASA services. They undergo formal Accreditation through Department of Health and Human Services (DHHS), the funding body.

Staff are supervised and meet professional standards as required e.g. Psychologists are registered with Australian Health Practitioner Regulation Agency (AHPRA) and endorsed as supervisors if that is a function of their role; Social workers are members (or must be eligible to be members) of Australian Association of Social Workers (AASW) Art therapists are registered with the Australian & New Zealand Art Therapy Association (ANZATA); and Child Psychotherapists are registered with the Victorian Child Psychotherapy Association (VCPA).

Advocacy Services as well as counselling services, crisis intervention and support services are part of the services provided; all of which are interlinked. Advocacy services are provided for individuals, as well as for groups, through peak body, political Lobby group liaison, consultation and acting as a 'pressure group'.

Further to this clients often require a care management service, which, although not a specific role of CASA, is often provided as other services are unresponsive, or simply too under-resourced to provide such a service.

Waitlists represent a significant problem in the current service system. If children and young people and their families have to wait for services the child/young person can develop both entrenched problematic behaviour and an entrenched sense of hopelessness and disempowerment. If the abuse and its impact is ignored other problems can occur for the child/young person and their family members.

2. What does not work or can make things worse or be harmful for victim/survivors?

What do victim/survivors need but not receive?

What victim/survivors need but do not always receive is outlined below:

- Victim/survivors need, but do not always receive, a client centred/client driven approach. For children and young people this also means a family focused approach.

Children and young people live in the context of their family/carers. This care system is critical in supporting their recovery from trauma and should be an integral part of any services provided. It is also common that at least one of the parents (usually the mother; Gatehouse Centre data suggest 72% of mothers of the children referred) of a child/young person presenting with a history of sexual abuse, has their own history. Supporting this parent to both manage their own responses and to better understand and support their child, is critical to the process of recovery.

Victim/survivors also benefit from being supported to develop a sense of agency in the telling of their story that allows them to tell it once (rather than over again) and where necessary across time and in the context of a safe relationship. Research tells us that victim/survivors tell us about their abuse in “snippets”. The brain’s capacity for recall is constrained by the experience of relational trauma, often leaving victim/survivors unable to provide a coherent narrative of what happened to them. Children, especially do not tell their entire experience in one go, as not only are they dealing with the neurological impact of their trauma, but they are simultaneously attempting to stay safe in a world that has become unsafe, through assessing the impact of telling their story gradually. They test out how their story will be received. However we have a child protection/legal system that responds to a single disclosure without hearing or taking the time to gather the child’s entire experience.

Furthermore, telling their story over and over again and in minute detail can reinforce a sense of invalidation, hopelessness and disempowerment for children and young people. Children in particular can feel that either their voice is of no significance or that they are not important enough to be helped (I’ve told you and you do nothing to help).

- Victim/survivors need to tell their story in a Video and Audio Recorded Evidence (VARE)that can be used by the Legal system, Police, Child Protection etc., as their accepted account and not be just for use by Police for a criminal investigation as is the case within Victoria. Child Protection, DHHS have very little role in these investigations and are not permitted to view the VARE when completed. It is our understanding that a subpoena is required for Child Protection to obtain a copy of the VARE.
- To be believed/heard when they tell. The criminal justice system in particular by its nature, forces the victim/survivors to prove they have been abused.
- For their developmental stage and its impact on their capacity to recount their experience and respond to questions. Children can appear to understand what is expected of them, yet in essence they may be responding in ways that adults misconstrue if they do not consider the child’s developmental stage.

- A policy of Child Protection DHHS and Victorian Police Sexual Offences and Child Abuse Investigation Teams, (SOCIT) planning together responses to allegations of sexual abuse together and to include consideration of joint interviewing
- An Assessment of the impact of the abuse by therapeutic services before treatment begins.
- Goals for treatment that are developed after the Assessment and agreed to jointly with victim/survivors.
- Treatment Goals that are reviewed regularly with the victim/survivors.
- Case management services from designated case managers, rather than from professionals who provide the victim/survivor with therapy services.
- An immediate service. Most services (if locally available) have waiting times that can make life very difficult and behavioural problems can develop.
- A transparent, collaborative process that fosters a sense of agency and involvement in decision making. For example, some families/young people do not want to have the Police involved but this choice can be taken out of their hands.
- Giving evidence in a context where they do not have to see/be in the same room as the offender. The Child Witness program in Victoria is a great assistance to children and young people, however even seeing the offender on camera can be significantly distressing for children.
- Further to the above, greater care is required within the out of home care system and Juvenile Justice system when anticipating the risk young people may face from other young people with regard to sexual and other forms of harm. We recommend the proposal of the Victorian Child Safety Commissioner's recent report into sexual exploitation of young people, that planning panels with independent expertise in sexual assault oversee decision making with regard placements.

3. What helps or facilitates access so victim/survivors receive what they need?

What are the barriers to receiving advocacy and support and/or therapeutic treatment and how might these barriers be addressed?

Barriers to receiving advocacy and support/therapeutic services include:

- A lack of availability of services
- Services that are unresponsive to individual needs
- Limited resources which result in long waiting periods for services. As a result of such limitations and waiting periods, some victim/survivors may choose to access a private service. Such services, however are also often constrained by 10 session (or fewer) models as available through the Medicare Better Outcomes in Mental Health program and/or professionals who lack specific experience in working with particular areas of child sexual abuse, or sexually harmful behaviour, including: sibling sexual abuse, sexual abuse of diverse victims/survivors (e.g. children and adults with intellectual disability, autism spectrum disorders, etc.).

- Service limitations e.g. only funded for x number of years, not seeing older boys who have engaged in sexually harmful behaviour
- A lack of collaborative practice/work with other sectors of the service system.
- Seeing private practitioners who are not experienced, supervised, or able to provide advocacy services as part of their practice.
- Silo funding model which inhibits flexible practices.
- Services (including Government agencies such as Child Protection DHHS and the Courts, Department of Justice (DOJ) and non-government agencies) which fail to listen to clients, be respectful, non-judgemental, and which are not integrated with other services which provide responses to victim/survivors.
- Services not prioritising needs in the context of the best interests of the children, young person and their family.
- Pornography and the use of the internet to abuse children and young people and the adult world's failure to manage this.

Factors which facilitate receiving advocacy and support/therapeutic services include:

- Accessibility, which can be addressed through –
 - Physical location
 - Skype IT services
 - Flexible hours
- Bringing a Family focus to service provision – regardless of what “family” or “family system” might be for each victim/survivor
- Services being Child Centred and informed by developmental and trauma focused principles
- No Waiting list/time

How to address the Barriers?

The following factors could address the above barriers:

- A more integrated funding model
- The Victorian Multi-Disciplinary Centre (MDC) model across the country
- A collaborative model, including regular, formal communication between agencies
- Service evaluation/feedback by victim/survivors that is incorporated into ongoing service development
- Joint research between agencies with a focus on children, young people and families
- Adequate funding for services and research that allows agencies to have designated positions for research staff.
- The use of developmentally appropriate, trauma informed services, with professionals skilled in working with children and young people and their family system

- An ongoing staff development program like the Victorian Workforce Development Program that provides training to new and advanced practitioners in the Victorian sexual assault sector.

4. (A) How well do advocacy and support and or therapeutic treatment services currently respond to the needs of secondary victim/survivors?

There is an inconsistent response across the sector as funding is rarely assigned to secondary victim/survivors. Ultimately, in the case of children and young people, this inconsistency either constrains the effectiveness of services provided to them (as it neglects their care context) or the resources of services which do provide a supportive response to secondary victim/survivors became unsustainably stretched; the consequences of which inevitably is increased waiting terms for the services to the primary victim/survivor.

(B) How would these services be shaped so they better respond to secondary victims?

Changes in the service system that could facilitate a better response to secondary victims/survivors include:

- Recognition that services for secondary victim/survivors are essential. This includes broader systemic changes that recognise the necessity of a broader family focus, e.g. currently Victims Of Crime Assistance Tribunal (VOCAT) does not provide support to secondary victim/survivors if the primary victim/survivor is over 18 years, even if that person has a recognised intellectual disability/serious mental illness and is heavily dependent on the support of their family. In the case of children and young people who have been sexually abused, secondary victims include siblings and parents/carers, all of whom are impacted by and critical in the recovery of the child's experience.
- Resources and funding for services that are commensurate with the demands of providing child centred, family focused services and which recognise that there may be multiple secondary victim/survivors.
- Dedicated funding and services for secondary victim/survivors that do not detract from that provided to primary victims/survivors
- Services that treat children and young people within the context of their family/care system rather than in isolation. Whilst the level of engagement of the family/care system may vary as a function of a broad range of factors, there needs to be a recognition that to see a child/young person in isolation of their care context is bad therapeutic practice.

- Children and young people can be secondary victims also. They can suffer Post Traumatic Stress Disorder (PTSD) and other psychological/emotional issues and exhibit behavioural disturbances when adult family members are victims of sexual abuse. Many take on the role of carer/protector for their parent, with little understanding from others that this is a role they have simply taken on. Others may not demonstrate overt negative impacts/externalised behaviours; however the likelihood that their sense of the world around them, their agency within that world and their template for relationships will have been impacted is significant. This group of secondary victim/survivors is rarely recognized or provided with any service, particularly in adult centred services.
- Services that recognise and professionals who understand and are trained in working with the complexity of family dynamics, particularly where complex attachment and trauma issues are present (as they are in most cases where children and young people have experienced child sexual abuse or engaged in/been impacted by sexually harmful behaviour).
- Services that recognise the importance of clinical supervision of professionals who provide therapeutic treatment services to victim/survivors and who provide such supervision and/or provide protected time for supervision.
- Services that recognise that professionals working with relational trauma will inevitably be vicariously impacted by that trauma. The Sanctuary Model (www.sanctuaryweb.com) provides a framework both for services/agencies to recognise and manage such impacts and for professionals to also apply in their work with victim/survivors.
- Restorative Justice can be beneficial and should be developed as an option for children, young people and their families. Children at times want to speak to their family members who perpetrated the abuse to tell them about the impact the abuse had on them or how angry they are with them.

Topic B: Diverse victim/survivors

1. Diverse victim/survivors can include:
 - Children, young people and adults with special needs/physical or intellectual disabilities/mental illness/substance abuse issues
 - Young people in the Juvenile Justice system (Youth Justice System)
 - Children & young people in Residential Care
 - Children & young people in Detention
 - Children & young people with absent parents/parents in incarceration, etc.
 - LGBTI Community
 - Indigenous Communities
 - CALD communities
 - Children & young people who present with no apparent symptomatic behaviour at the time of presentation

Diverse groups are often provided specific services with existing sexual assault services. Their needs are many and varied and can be best addressed through wrap around services within and across agencies and their communities (e.g. services based within Culturally and Linguistically Diverse Communities(CALD) or indigenous communities and which engage community members who are central in the child/young person's life).

Service provision to children and young people with particular special needs (e.g. with significant mental health needs, intellectual disability, young people in the juvenile justice system, young people receiving drug and alcohol (AOD) services, etc.) is often constrained by a lack of understanding and collaboration between these services and sexual assault services. Models of practice should be characterised by collaborative practice between sexual assault therapeutic services and the diverse groups' specialist services to ensure that specialist needs are reflected in practice.

Education and training around the needs of diverse groups is required to facilitate understanding that underpins sensitive practice is also critical.

It is worth noting that at times families/young people from diverse communities do not want to be seen outside of main stream services. They do not want this identification.

**2. How can their needs be better met?
What needs to be in place to achieve this?**

The needs of diverse groups can be better met through having:

- Case management by the specialist (diverse groups') service
- Treatment/Therapeutic agencies working in collaboration with specialist diverse services to provide therapy and support.

This service model needs:

- To be reflected in funding agreements and have targets attached to achieve this collaborative approach
- To be part of the formal DHHS Accreditation Reporting processes
- Ongoing formal, regular communication and understanding between these agencies (including possible Memorandum Of Understanding (MOU)
- Ongoing training and education around the needs of diverse groups
- Joint evaluation and research across services to develop evidence based practice

3. What would better help victim/survivors in correctional institutions and upon release?

- Continuity of comprehensive support services in prison and upon release, including case management support
- Active follow up once released

- Young people in correctional institutions often feel safe for the first time and want to explore their behaviour and ways to help them. Therapeutic services that are characterised by the qualities noted above (Topic A, questions 1 & 2).
- The commencement of a working relationship aimed at developing trust and which can be continued after release, when a more specific treatment focus can be developed, would be helpful.
- In prison workers can run psycho-education groups, that are not necessarily in relation to experiences of assault that assist victim/survivors to develop positive relationships. On release they may then be able to engage more effectively with therapy and other supports.
- Where victim/survivors are in correctional institutions and their children are receiving therapy for their own experience of sexual abuse or issues regarding sexually harmful behaviour, the capacity to engage the child's parent (with the child's knowledge and consent and in line with any orders regarding contact and parental responsibility) is important. Such engagement could be useful at different points throughout the child's treatment, but particularly at the point when the parent is due for release where contact between the child and parent is anticipated. In this way, parents can be helped to understand their child's experience and support them in their ongoing therapy.

Topic C: Geographic Consideration

1. Outside Metro Region

Challenges to accessing advocacy, support and therapeutic services for those outside the metro region can include:

- Travel time and cost
- Lack of services
- Small communities where everyone knows your issues
- Sole practitioners with no collegial support, supervision, or service infrastructure
- After-hours services are more difficult to provide as a result of limited resources. After-hours services require an agency to have a core group of staff who can provide such a response.
- Workers seeing/meeting clients constantly after-hours
- Waiting times/lists as a result of limited resources
- Qualifications, developing and maintain professionals' skill base, recruitment and retention of staff all pose difficulties
- Appropriate facilities to provide services can be limited

2. What would help/Innovation?

The following may address the above challenges:

- Increased funding; including funding dedicated to the provision of external supervision
- More resources
- Increased availability of IT resources, skype, webinars for training. Links do not have to be face to face. What is needed in most cases are the resources/facilities and technical expertise.

Topic D: Service System Issues:

1. Terminology:

Terminology in the sector changes often without clearly understood reasoning. This can lead to professionals being unaware of such changes, or simply resisting change. The Victorian Centres Against Sexual Assault (CASA) are moving towards using the descriptors: people/children/young people who have been sexually assaulted/abused; children/young people for whom sexual abuse is suspected. This is in line with the introduction of the terms: children with problem sexual behaviour, and young people with problem sexual behaviour in the mid 2000s, when the sexually abusive behaviour treatment services were developed and integrated into the Victorian CASA service system.

2. Resources:

While the MDC model is being slowly rolled out across the state of Victoria, resources across regions vary widely. The MDC model's strengths include:

- Being conducive to collaborative practice
- Offering victim/survivors a one stop shop
- Offering victim/survivors a wrap-around service
- Regular, formal communication between those involved in providing services.

3. Skilled Practitioners:

The service system faces a range of issues in regards to the recruitment and retention of skilled practitioners and the ongoing development of staff skills and accreditation of services:

- Credentialling/qualifications. Services can be constrained by funding in regards to which professionals they can employ or by the capacity to actually attract staff (e.g. to rural areas). In regards to recruiting clinicians with skills and experience in working with young children or with children and young people with sexually harmful

behaviour, the pool of suitable clinicians is limited. This limited pool of skilled clinicians often means that clinicians are “head hunted” from one service to another.

- Providing ongoing education and skills development. The Victorian sector has a Work Force Development program to address this issue with workshops and seminars provided at both introductory and advanced levels for clinicians working with children and young people who have experienced sexual abuse OR who have issues with sexually harmful behaviour, as well as those who work with adults who have experienced sexual assault or childhood sexual abuse. Professional Development is a critical and part of addressing the well-being of both clients and clinicians. Some professions have clear expectations to be met regarding their ongoing professional development (e.g. psychologists). However, there should be guidelines around minimum expectations for professional development for all clinicians in the sector. Service systems should also be assisted to develop programs that can be linked to tertiary education services, externally evaluated and credited as recognised courses.
- Accreditation – a formal process is both important, but also time consuming and does not allow for the impact that this then has on the provision of services to victim/survivors
- Supervision is essential to any clinician working in the sexual abuse/assault sector; both in terms of providing best practice services to clients, but also in terms of protecting the well-being of clinicians and promoting ongoing skill development and education.
- Standards of Practice are critical documents. Processes need to be in place to facilitate their implementation and accreditation as well as processes for situations where standards are not met and for addressing complaints about the processes and standards.

4. Additional essential service system issues that require attention

- Agency based approach

An agency based approach to the development of a Service Model is preferable to a private/sole practitioner model. Agencies are better placed to provide supportive infrastructure and develop and maintain collaborative relationships with other organisations in and related to the sector. Private practitioners can provide excellent services to victim/survivors, but particularly when working with children and young people, the demands of engaging and working with the system that supports these victim/survivors can be beyond the resources of private practitioners. Children and young people require a supportive carer and a funding model that enables participation across a system that works with and understands complex families.

- Data collection

We require a national data system that is able to look at and review incidents/difficulties/complaints and to evaluate services that are beneficial or less effective.

An overview of what services exist, what they provide and how effective they are needs to be conducted at a national level. This will facilitate a view of national trends, evaluation of current practice and the ongoing refinement and development of best practice.

Topic E: Evidence and Promising Practices:

1. Innovative practice:

Innovative practice in Victoria has included:

- The use of a child centred, family focused framework. The provision of service to whole families where the victim/survivor has experienced abuse at the hand of a sibling who is a young person. The CEASE (Peak Body) Practice Standards for Sexually abusive treatment services programs, provide an example of a framework that seeks to integrate therapeutic practice across families and care systems, such that the needs of young people who have been harmed and have caused harm can be considered together. This is particularly important when assisting parents address sibling abuse and abuse within extended family networks.
- The development of a 4-6 session assessment model that incorporates history taking, observation and administration of standardised assessment tools, family, dyadic and individual sessions
- Therapeutic Specialist workers attached to residential units to provide assistance to residential services staff who are supporting residents with issues regarding sexual abuse/assault or sexually harmful behaviour
- Treatment goals that are designed collaboratively with victim/survivors and their care system
- Risk Assessment/safety plans that are designed collaboratively with victim/survivors and their care system
- The recognition of the dynamics of shame and of hope in, respectively, constraining victim/survivors from engaging in therapy and assisting victim/survivors to create new meaning around their experience
- The development of flexible interventions that include any combination of:
 - Individual, family, dyadic or group therapy
 - Mindfulness based interventions, sensorimotor based/neurodevelopmental interventions, family therapy, creative art therapy, sand tray therapy, play therapy, etc.
- Psycho-educational groups for young women in Secure Welfare settings (Youth Justice Service) targeting issues around sexual exploitation, self-esteem, resilience and confidence
- Participatory action research groups with young people to explore issues around sexual exploitation and consent to develop materials that engage young people
- Services developed to meet the complex needs of and constraints to engaging children in detention.

- Ongoing training packages being delivered to a broad range of professionals working with children and young people, and community groups in regards to the recognition of and pathways of response to child sexual abuse and sexually harmful behaviour

2. Evaluation:

Evaluation has been conducted through:

- Client feedback – using the Partners in Change Outcome Measures developed by Scott Miller et al
- Stake-holders feedback
- Exit interviews on completion of service provision
- Group program review
- Quality programs designed to evaluate and develop ongoing clinical practice

3. Learnings from practice-based evidence and grey literature:

Research by practitioners at Gatehouse Centre, RCH, is outlined below.

- *Phd Thesis, (2014): Finding hope in our back pockets.*

Recent research around practice principles for working with sibling sexual abuse has led to further understanding of how therapists make sense of, speak about, work with and are challenged by SSA. It identified the importance of compassion satisfaction and the idea of hope in sustaining therapists whilst they undertake such challenging work. Key findings and recommendations for working with SSA were made in regard to the use of a collaborative approach with both colleagues and families, the use of clear, non-judgemental language that recognises the impact of SSA on victims and assists the young person who perpetrated the abuse to be accountable, whilst remaining aware of and balancing the different perspectives, understandings and therapeutic needs of all family members. Recommendations regarding the support of therapists included the importance of space and time to think about the work and its impact on therapists and of bringing hope into the therapist's frame of reference. This action research has also led to a number of conference papers, the development of seminars and workshops to develop therapists' understanding of and skills in working with SSA, scholarly contributions to journals and consultations to therapists both within and outside the sexual assault sector.

- *Masters Thesis, (2015): Capturing mothers' experiences of hearing their children disclose sexual abuse when they too have a sexual abuse history.*

This project has sought to deepen understanding of the experiences of mothers with a history of childhood sexual abuse, on hearing their children disclose their own sexual abuse and what supports if any, they received during this experience. In broadening this understanding the researcher has highlighted the critical nature of practitioners remaining aware of these mothers' experiences in regard to any work that may be undertaken with their children. The findings have also demonstrated the importance of the first response to children's disclosure, the role this plays in determining those children's resilience and the considerable challenges that mothers face upon hearing their children's disclosure, including a legal and welfare system that often dismisses reports made by mothers on behalf of their children. This research has provided further confirmation of a culture of mother blaming within both the professional and general community that leaves mothers experiencing shame, blame and powerlessness – often factors which inhibit their capacity to support their children through their own process of recovery. The role of therapists (and other professionals who work with victim/survivors) in bearing witness to and engaging in the process of remembering with mothers to enable them to feel heard, supported and empowered was stressed. Additionally, mothers were given opportunity to voice their need for further education and support groups

for themselves, parenting assistance within the home, improved access to lengthier interventions and improved communication from professionals in relation to their children.

- *Masters Thesis, (2010): Towards an understanding of children and young people who exhibit sexually abusive behaviour: The implementation of therapeutic treatment orders in Victoria*

This research sought to better understand the presentation and treatment of children and young people who exhibit sexually abusive behaviour. The findings indicated that these children and young people often presented with a range of comorbid psychopathology in the context of developmental experiences of cumulative trauma, insecure attachment and significant disruption to all areas of functioning. Many had experienced difficult family circumstances (in particular family violence), disrupted attachment and/or been exposed to pornography. The findings suggested that treatment approaches with these children and young people are best framed within developmental (especially attachment theory), family systems and trauma frameworks.

- *Masters Thesis, (1999): A phenomenological study (using creative interventions) of two children who have been victims of sexual assault.*

This research explored the importance of understanding the concept of the “lived body” and the ability of the body to hold memories, as well as the ability of movement based creative interventions to engage the “lived body” and potentially access old patterns of experiencing the self. The findings demonstrated the importance of understanding: the intersubjective response in the therapeutic encounter, the concept of the “lived body” and the ability of the body to hold memories, as well as the effectiveness of creative interventions for the treatment of sexual abuse trauma in children and young people.

- *Masters thesis, (2013): Risk assessment and psychoanalytic psychotherapy of a young man engaged in sexually harmful behaviours*

A single case study research was conducted as part of Child Psychoanalytic Psychotherapy training. The research highlighted how long term psychoanalytic psychotherapy was able to significantly reduce the risk of further harm occurring by a boy who had been sexually abused, and engaged in sexually harmful behaviours. Central to the research was understanding the pivotal role of the therapeutic relationship and the application of a psychoanalytic framework.

- *PhD Thesis (current): The intergenerational transmission of trauma in adults who were raised in institutional care in Australia.*

This PhD has grown from reflection upon the staggering number of submissions received for the Senate Community Affairs Reference Committee by adults who grew up in institutional care and the number of submissions that are being received for the 2013 Royal Commission on Institutional response to child sexual abuse, and from the hypothesis that the

attachment relationships these adults had as children with their primary caregivers were marked by abandonment, ambivalence, abuse and terror. The purpose of the proposed research is to examine the impact of growing up in institutional care on survivors' parenting and the relationships they have with their children; to examine the intergenerational transmission of trauma of parents to their children and deepen understanding of how this transmission impacts children.

Learnings from Grey Literature:

Services being provided by The Gatehouse Centre to children and young people presenting with either experiences of sexual abuse and/or sexually harmful behaviours, are strongly influenced by the literature regarding neurodevelopmental, mindfulness and sensorimotor interventions (e.g. Bruce Perry, Dan Siegel, Babette Rothschild, Janina Fisher), attachment based interventions (e.g. Dan Hughes, Patricia Crittenden, Gary Diamond), Family therapy (including contextual family therapy, narrative family therapy and structural family therapy), developmental theory and trauma frameworks (particularly the Sanctuary Model).

These frameworks highlight such concepts, critical to the service provision to children and young people, as:

- The making of meaning associated with experiences of trauma
- The role of the brain, mind and body in storing, remembering, re-experiencing and integrating experiences of trauma
- The role of context, family and system in validating, witnessing and understanding a child or young person's experience of trauma and in facilitating their journey of integration and development post this trauma
- The role of shame in constraining recovery from experiences of sexual abuse
- The role of hope in facilitating integration following and recovery from sexual abuse.