WESTERN SYDNEY
UNIVERSITY

Royal Commission Into Institutional Responses to Child Sexual Abuse
Submission on Advocacy and Support and Therapeutic Treatment Services

Dr Michael Salter
School of Social Sciences and Psychology
Western Sydney University
Locked Bag 1797
Penrith NSW 2751
Email: michael.salter@westernsydney.edu.au
Phone: +61 2 9772 6539

Background

I am a Senior Lecturer in Criminology at Western Sydney University specializing in research with adult survivors of child abuse. I also sat on the board of Adults Surviving Child Abuse from 2007 – 2010 and have extensive experience as a community advocate for adult survivors.

My book *Organised Sexual Abuse* (Routledge, 2013) was based on the findings of a qualitative study with adults reporting multi-perpetrator sexual abuse in childhood. It was the first Australian study of its kind, and included extensive analysis of sexual abuse in institutional settings. The book addresses survivor accounts of organised abuse in institutional settings such as schools and residential children's homes, as well as more opportunistic incidents of the sexual abuse of children who were also being abused in the home setting.

I have undertaken other relevant research including an interview study with adult survivors of child sexual abuse in alcohol and drug treatment, and with the alcohol and drug workers who treat them. This study was conducted with Associate Professor Jan Breckenridge and the results have been published in international journals and edited collections.

I continue to undertake qualitative research with adults describing sexual abuse and violence in childhood and adulthood. I've recently interviewed a number of adults who have also provided testimony to the Royal Commission about their childhood abuse in various institutions. I am also conducting interviews with mental health professionals and social workers on 'best practice' approaches with severely abused adult clients.

My responses below pertain primarily to adult survivors of abuse, since this is my primary area of expertise, but may have relevance to child victims.

Topic A: Victim and survivor needs and unmet needs

1. What advocacy and support and/or therapeutic treatment services work for victims and survivors?

Ideally, therapeutic treatment services for adult survivors will be flexible and integrate multiple modalities according to the varying needs of individual clients. This is should include individual counselling provided by a trained counsellor, psychologist or psychiatrist who specialises in abuse and trauma. Interventions such as EMDR have been shown to be effective but should be part of a larger treatment approach. Survivors may also benefit from skills-based group work in which clients rehearse and enhance emotional and life skills.

Dialectical Behaviour Therapy has been shown to be very effective in providing adult survivors with cognitive and emotional skills that are dysregulated by abuse and trauma (Linehan, 1993). Failures of emotional regulation can underlie relationships problems, substance abuse, impulsivity, self-harm and suicidality. Dialectical Behaviour Therapy promotes a model of integrated one-to-one counselling, group work and telephone support that has proven to be successful in ameliorating the mental health impacts of child sexual abuse (e.g. Bohus et al., 2013). Unfortunately, the availability of this approach is very limited in Australia.

Pharmacotherapy is an important part of recovery for many survivors, however many survivors report that it is difficult to find a psychiatrist with sufficient experience and knowledge of abuse and trauma. It is common for survivors to seek abuse-specific treatment from a psychologist or counsellor while the role of their psychiatrist is primarily to manage their medication. This arrangement is fine for some survivors but, given that it's often difficult to find abuse-specific treatment, survivors may find that the only treatment available to them is pharmacotherapy and they are not being supported to make gains in other areas of their life. This can be quite demoralising.

Early intervention services for young people exhibited behaviours that have been linked to abuse and trauma, such as self-harm, substance abuse and 'personality disorders', can be very effective. These are often informed by Dialectical Behaviour Therapy and psychodynamic approaches (e.g. Geddes, Dziurawiec, & Lee, 2013). Unfortunately, teenagers exhibiting these behaviours are often stigmatised and lack support in a range of settings. Early intervention services in mental health are focused on identifying illnesses such as depression, psychosis and schizophrenia rather than abuse-related mental illness.

2. What does not work or can make things worse or be harmful for victims and survivors? What do victims and survivors need but not receive?

Non-specialist treatment: It is very difficult for adult survivors to access abuse-specific mental health care. Some symptoms of abuse-related mental illness, such as depression, may be addressed by non-specialist services and practitioners. However there is a lack of specialist services or trained clinicians to address abuse-specific mental health symptoms, such as flashbacks and dissociation. These symptoms are unlikely to abate without

treatment yet survivors often report self-managing them over years despite frequent presentations to mental health services.

Inflexible service provision: A key problem facing adult survivors it that the mental health system remains orientated around diagnosis rather than need. Those clients with multiple or complex needs often accumulate multiple diagnoses and are faced with fragmented care from multiple services, which can be disorientating, invalidating and difficult to manage. Survivors may find that some of their needs are being met while related but pressing needs are being ignored, which impairs recovery and inhibits trust with service providers. This is particularly the case for adult survivors who don't have access to the private health system.

Diagnostic practices: There is no specific abuse-related mental illness but rather a broad syndrome of symptoms that can potentially fall under a range of diagnoses. These symptoms may co-occur alongside other mental illnesses that have been 'triggered' by trauma or whose progression has been impacted by abuse. Adult survivors often move through the mental health system collecting a series of diagnoses, none of which acknowledge the traumatic aetiology of their illness. Furthermore, many survivors complain that mental health diagnoses are communicated to them in an inappropriate way. Where mental health diagnoses are not accompanied by explanation or referral to appropriate care, it is questionable what function the diagnosis serves in the first place.

Stigma and discrimination: Abuse survivors can be stigmatised in hospitals, alcohol and drug and mental health settings for common abuse symptoms such as self-harming, substance abuse and so-called "personality disorders" (Aviram, Brodsky, & Stanley, 2006; Bjorklund, 2006; Salter & Breckenridge, 2014). These symptoms are all treatable but may be labelled health staff and others as "attention seeking" and malingering. This is a form of discrimination that can alienate survivors and inhibits them from seeking help in the future.

3. What helps or facilitates access so victims and survivors receive what they need? What are the barriers to receiving advocacy and support and/or therapeutic treatment and how might those barriers be addressed?

Coordinated care: Survivors may have multiple needs but struggle to identify where those needs can be met, what the progression of recovery might look like, and how they are going to cope when recovery is challenging or confronting. Survivors would greatly benefit from an established rapport with a care provider who can provide assistance in coordinating their care and support needs.

Trauma-informed care: There are a number of settings in which adult survivors of child sexual abuse are likely to present, including mental health services, inpatient wards, alcohol and drug services, sexual assault services and domestic violence services. Many of these services provide models of trauma-informed and sensitive care, and it is clear that this enhances the efficacy of the support that they provide. However other services can lack sensitivity to trauma and abuse.

Referral pathways: A lack of specialist services and programs for adult survivors means that non-specialist service providers may have limited or no referral options when a client discloses a history of sexual abuse. I have had health practitioners tell me that they do not believe it is safe or ethical to ask clients in their service about their abuse history, even when this may be relevant to treatment, because their service could not offer appropriate support, and they have nowhere to refer the client to.

Trauma screening: Where services are trauma-informed and/or referral options are available, it may be appropriate to screen for a trauma history as part of an intake process in a service. There are a number of sensitive instruments available for practitioners in order to take a trauma history.

Supporting disclosure: It is important that health and welfare practitioners respond appropriately to a disclosure of sexual abuse, and enable those disclosures to take place where the client feels it is necessary. Being disbelieved and invalidated is at the core of the experience of sexual abuse for many victims, and has a major role in traumatization and the development of abuse-related mental illness. This pattern can be perpetuated where practitioners are seen by the client to respond inappropriately to a disclosure of sexual abuse, leading to unwillingness to disclose in the future.

Public conversation on mental illness: National advocacy services and public campaigns generally promote a biomedical explanation of mental illness that does not acknowledge the significant role of abuse. For example, it is well recognised that women experience higher rates of depression and anxiety than men due, in part, to the greater victimisation of girls in child sexual abuse (Ussher, 2010). However the most prominent mental health 'ambassadors' in Australia are often male politicians and sportsmen, and abuse and trauma are rarely mentioned in relation to depression and anxiety. Abuse as a major driver of mental illness is generally overlooked in public awareness campaigns.

Topic D: Service system issues

1. Given the range of services victims and survivors might need and use, what practical or structural ways can the service system be improved so it is easier for victims and survivors to receive the advocacy and support and/or therapeutic treatment services they need? What type of service models help victims and survivors to receive the support they need?

There is a lack of public funding for effective mental health care for adult survivors of child abuse. Over the last ten years, a number of specialist providers have had funding cut or cease altogether. Some mental health or women's services may provide short-term group courses for adult survivors and, while these can be very useful, they don't provide the kinds of intensive and individualized care that many survivors need to make a full recovery. Australia has very few publicly funded, targeted therapeutic services for survivors.

2. How can we ensure practitioners and workers are sufficiently skilled to provide advocacy and support and/or therapeutic treatment for adult and child victims and survivors, including those from diverse backgrounds?

All prospective mental health professionals should receive training in abuse and trauma at university. Currently, most university curricula in the areas of clinical psychological and psychiatry does not adequately address the role of child sexual abuse in the aetiology of mental illness. As a result, many graduates are poorly equipped to identify or treat adults with histories of child sexual abuse. In contrast, child sexual abuse is generally much better addressed in social work training. There is a need for more specialist practitioners in this area. It is very common for survivors to find that all psychologists and psychiatrists that specialize in trauma in their city or local area are not taking new clients. There is also a need for specialist inpatient services for trauma and dissociation. Australia currently only has one such ward, based at Belmont Hospital in Brisbane.

References

Aviram, R. B., Brodsky, B. S., & Stanley, B. (2006). Borderline Personality Disorder, Stigma, and Treatment Implications. *Harvard Review of Psychiatry, 14*(5), 249-256.

Bjorklund, P. (2006). No man's land: Gender bias and social constructivism in the diagnosis of Borderline Personality Disorder. *Issues in Mental Health Nursing, 25*(1), 38–44.

Bohus, M., Dyer, A. S., Priebe, K., Krüger, A., Kleindienst, N., Schmahl, C., . . . Steil, R. (2013). Dialectical behaviour therapy for post-traumatic stress disorder after childhood sexual abuse in patients with and without borderline personality disorder: A randomised controlled trial. *Psychotherapy and psychosomatics, 82*(4), 221-233.

Geddes, K., Dziurawiec, S., & Lee, C. W. (2013). Dialectical behaviour therapy for the treatment of emotion dysregulation and trauma symptoms in self-injurious and suicidal adolescent females: A pilot programme within a community-based child and adolescent mental health service. *Psychiatry journal, 2013*.

Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Salter, M., & Breckenridge, J. (2014). Women, trauma and substance abuse: Understanding the experiences of female survivors of childhood abuse in alcohol and drug treatment. *International Journal of Social Welfare, 23*(2), 165-173. doi: 10.1111/ijsw.12045

Ussher, J. M. (2010). Are We Medicalizing Women's Misery? A Critical Review of Women's Higher Rates of Reported Depression. *Feminism & Psychology, 20*(1), 9-35.