



Finding a place for healing: Women survivors of childhood sexual abuse and their experience of accessing services

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Abstract

Women survivors of child sexual abuse often suffer a range of difficulties including a chronic and painful sense of insecurity, a lack of self-esteem, difficulty with interpersonal relationships, poor frustration tolerance, overwhelming emotions, depression, sensitivity to criticism and rejection, distrust, suspiciousness and a fragile sense of self. They may also experience a range of serious psychological consequences, their life trajectory often marked by chaos and complexity. In Australia, services have been developed in government, non-government and private sectors to meet the needs of these women; however, anecdotal evidence suggests that services may be patchy in both availability and standards. The aim of the *Reframing Responses* study (O'Brien, Henderson & Bateman, 2006) was to explore the provision of services in the non-government sector. This paper presents findings related to the experiences of women survivors of child sexual abuse in accessing and utilising services. A qualitative study design was used. Fourteen women participated in focus groups and interviews to provide rich descriptions of their experiences of disclosure, accessing services, what was helpful, and what was unhelpful. The women provided descriptions of their experience of services across all sectors. They confirmed a lack of availability particularly in terms of longer-term counselling, a lack of consistency in terms of models and standards, and provided clear indications of what was helpful and what was not. The findings of this study have implications for the development of services for consistency in standards of services, models, and needs for training and education.

Keywords

childhood sexual abuse, survivors, non-government organisations, therapy, borderline personality disorder

Introduction

Women survivors of childhood sexual abuse (CSA) have been identified as a particularly vulnerable group in society. They are disadvantaged not only by the trauma associated with sexual abuse, but by accompanying socio-economic disadvantage. Some of the very survival mechanisms utilised to advantage in

childhood can prove counterproductive in adult life. These include a fierce independence with lack of acknowledgment of the need for help, and a reluctance both to ask for and accept help. Issues around trust, especially from those perceived to be in authority, can limit both contact and engagement with the people who can potentially provide the most effective help.

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Citation: O'Brien, L., Henderson, C., & Bateman, J. (2007). Finding a place for healing: Women survivors of childhood sexual abuse and their experience of accessing services. *Australian e-Journal for the Advancement of Mental Health*, 6(2), www.auseinet.com/journal/vol6iss2/obrien.pdf

Published by: *Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet)* – www.auseinet.com/journal

Received 28 November 2006; Revised 3 July 2007; Accepted 3 July 2007

Studies consistently demonstrate that adult survivors of CSA manifest high rates of mental illness, suicidality, substance abuse and poor physical health. Subsequently, utilisation of health services is demonstrated to be high in Australia (NSW Health, 1997) and the United States (George, Winfield & Blazer, 1992). However, service providers report that due to an absence of adequate resources and a need to prioritise recent sexual assault victims, survivors increasingly experience ongoing barriers to access since they do not present in 'immediate crisis.'

The support needs of this group of women may include housing and employment; education and training; medical care; pre-natal, maternal and child support; sexual assault, rape crisis and drug and alcohol counselling; long-term counselling; psychotherapy; and psychiatric services. In Australia, non-government (also termed not-for-profit) organisations (NGOs) provide most of the therapeutic services - therapy, counselling, practical assistance and support to this group of women. Often multiple agencies are involved. Because of the difficulties this group of women has in the experience of self and others, they present specific challenges to the provision of safe and effective services. Issues of re-traumatisation and re-victimisation are critical considerations as are the difficulties in accessing services due to lack of self-esteem. However, whilst there are studies investigating service delivery for victims of domestic violence and sexual assault, there is little research focused on service delivery to survivors of CSA.

The *Reframing Responses* study (O'Brien, Henderson & Bateman, 2006) sought to examine services provided by non-government organisations to women survivors of CSA. This paper presents information on the service needs of women who are survivors of CSA from the perspective of the women themselves.

Childhood sexual abuse

Information on the prevalence of CSA is frequently unclear due to the diverse definitions used (CASA House, 1997). Fergusson and Mullen (1999) concluded that overall, in situations in which children had been subject to

the sexual gratification of another, the prevalence rate was 1 in 3 women, and 1 in 6 men.

Abusive behaviours and assault, whether physical, sexual or psychological can create long-term interpersonal difficulties, distorted thinking patterns and emotional distress. Difficulties associated with abuse-related attachment may be mirrored in relationships throughout a survivor's life (Briere, 2002; Pearlman & Saakvitne, 1995).

There is an established body of knowledge clearly linking CSA with a range of psychological problems and psychiatric illnesses including: depressive and anxiety symptoms, substance abuse disorders, eating disorders, post-traumatic stress disorders in adults (Brewerton, 2004; Cozolino, 2002; Fergusson, Horwood & Lynskey, 1996; Kendall-Tackett, 2000; Mullen, Martin, Anderson et al., 1997; Silverman, Reinherz & Giaconia, 1996; Teicher, Anderson, Pokari et al., 2003); dissociation (Herman, 2001; Meares, 2005; Watson, Chilton, Fairchild & Whewell, 2006); Dissociative Identity Disorder (DID) (McLewin & Muller, 2006); and Borderline Personality Disorder (BPD) (Cozolino, 2005; Skodol, Siever & Livesley, 2002).

Services for women survivors of CSA

Women with CSA histories access services from a wide diversity of government, non-government and private health sectors. Services may include: mental health; drug and alcohol; sexual assault; accommodation; employment; community and women's health and counselling agencies; private psychologists; general practitioners (GPs); psychotherapists and counsellors; private hospitals; and survivor support organisations.

The Council of Social Service of New South Wales (NCOSS, 2004) stressed the need for increased access to support services for adult survivors, particularly in rural areas, arguing that it would minimise the impact on substance dependency and physical and mental health, and the demand on crisis and other mental health services.

The complexity of the problems related to the impact of CSA on the lives of women means that they require a range of practical support and

psychotherapeutic services. The difficulty in accessing these has anecdotally been known by both recipients and providers of services; however, studies identifying the requirements for services and the experiences of services were not identified.

Method

A qualitative, descriptive design was used, as a major aim of the study was to develop an understanding of the women's experiences of accessing services. The study was framed in the belief that the women participants were knowledgeable, able to describe their own experience, and that this knowledge was invaluable in understanding how services need to be delivered. The researchers came from a position of clinical and research interest in this area. The role of the researchers was one of empathic inquiry seeking understanding of their experiences.

Participants

Women survivors of CSA who used NGO services were invited to participate in focus groups or individual interviews via posters in client area of services, or through advertisements in email lists and newsletters. No invitations were issued to individuals directly, and volunteers contacted the researchers. Fourteen women volunteered to participate. Ten women participated in focus groups and four women were interviewed individually.

Ethical issues

The University of Western Sydney, Human Research Ethics Committee, granted ethics approval. No ethical issues were raised in the process of conducting the study. Participants were keen to respond to invitations to participate, and expressed gratitude in the interest in their perspective.

Data collection and management

Focus groups and interviews were conducted in centres providing services. Two interviews were conducted by telephone. Both group and individual interviews were taped and notes were taken. Focus groups used flip-charts to assist in synthesising discussion into major topic issues. Tapes of interviews and groups were transcribed.

The women were asked to describe their experiences of NGO services. Few prompts were needed. Clarifying questions were used when required. These included 'Can you describe a time when this happened?' 'Can you identify a really positive/negative experience of services?' 'What made a difference?' 'What is the best service you have experienced?' Discussion centred on a number of key issues: the context of seeking help, barriers and access, what was helpful, what was unhelpful, and service delivery gaps.

Data analysis

Transcriptions, notes and flip-chart notes were read and re-read and common issues were identified and grouped. The identified issues were organised into major categories. An advisory steering group also provided feedback on the completeness of the descriptions of the experiences.

Findings

Women survivors seeking help

Histories of participants included those whose abuse was perpetrated by close family members, frequently for protracted periods of time. Forms of abuse included sexual, physical and emotional abuse, rarely in isolation and often endured until they left home. They described chaotic lifestyles, lack of supportive adults, poor educational history, and being seen as rebellious and 'acting out' during adolescence.

The women described abuse of substances, involvement in further abusive relationships, difficulty relating, failure to complete education, prostitution, and poor work history and skill. '*Disorganised and dysfunctional*' was how one participant described her life. The women's difficulty in relating often excluded them from positive interactions, which further exacerbated their difficulties.

The women described being over-emotional, reacting strongly to situations and not knowing where the reaction came from. They described dealing with 'triggers' from the past - memories, incidents and fragments that were overwhelmingly emotional.

Some had subsequently experienced sexually abusive relationships, sometimes due to a lack of interpersonal skills and poor boundaries, whilst some were chronically fearful of close relationships, leading lives of isolation, terrified of sexual relationships and unable to trust anyone. Some described getting into risky situations, being sexually assaulted or raped, others married only to find their marriages marked by violence and abuse. A very small minority described good marriages that sustained them. Those who had children reported parenting difficulties, being either too fearful to set limits, or being so overprotective that they set unreasonable limits.

The women all suffered degrees of depression and anxiety with ensuing social difficulties. Many participants described not being aware of the repercussions of abuse, and not relating their life difficulties to the abuse. The memory of the abuse may have been successfully 'blotted out' until later traumatic events evoked recall.

Self-harm was common, with direct injury behaviours including cutting and burning. The participants also listed more 'indirect' injurious behaviours such as substance abuse and 'risky' lifestyles: *'I was dancing at clubs at 14, doing drugs and drinking.'* *'I was out of control, not protecting myself, wanting closeness but terrified if anyone got close.'* Self-harm and abusing substances was described as a way of coping with feelings: *'When it got too much – when I felt so strung out I was going to break into bits, I would cut myself, or get drunk or both.'* Suicidal ideation was common and often chronic: *'I thought, if it gets too bad I can always end it.'*

Repeatedly, the women described having no sense of 'self': *'There was nothing there.'* Lack of self-esteem was frequently described to the extent of self-hatred. They had difficulty asking for help, an inability to identify what help they needed, and lacked the capacity to take responsibility for the chaos in their lives.

Problems that took them to services

Some participants had been admitted to psychiatric hospitals as a result of suicidality, self-harm, depression, anxiety or psychosis. During such crises, links between their childhood trauma and their current mental state

were sometimes made. Other women were referred for services due to parenting difficulties, homelessness, or for counselling related to a range of problems. Recipients often found help later rather than sooner, and grieved the 'lost' years when no help was available. Many sought help themselves when they were overwhelmed by strong childhood memories of assault and abuse.

Experiences of disclosure

All participants discussed the experience of disclosure of CSA as frequently including minimisation of the effect of abuse. Comments such as: *'So what – your father molested you a bit!'* and *'Your uncle assaulted you – but you should invite him to your wedding, it was a long time ago'* were common.

The belief that there is no link between CSA and mental ill health, held by some psychiatrists, was one that the women found insulting and repugnant. GPs often did not understand, and seldom asked about the possibility of CSA, despite women presenting with a range of problems that may be indicative of trauma. However, one GP was noted to be 'wonderful,' providing a supportive relationship. Other participants' first disclosure was to specialist CSA services and this was commented upon positively: *'She just let me say what I wanted – didn't judge and wasn't shocked. She didn't question whether this was 'the truth.'* Some participants had tried to verify their memories with other family members prior to seeking help. Some realised that the family had known about the abuse, others were ostracised, whilst others found that abuse had occurred to other family members.

Services used by women survivors

Women participants reported that they used a range of health and counselling services from both government and non-government sectors, including: GPs, psychologists, psychiatrists, counsellors, psychotherapists, community psychiatric nurses, rape crisis services, women's health centres, groups from a range of community services, CSA specific services, Adult Survivors of Childhood Abuse organisations, mental health services (including child and adolescent mental health services),

accommodation services, educational counsellors (TAFE, University), and government departments (including community services, housing, and employment agencies). Some participants reported having accessed many services at one time or another, often concurrently.

Accessing services

Participants admitted to being highly sensitive to rejection and that any indication of impatience or diffidence would cause them to turn away from a service. They needed people at the front line (i.e., reception, intake) who understood their sensitivity and their background. Participants were aware that there were few, if any, rural, remote and outreach services for women survivors of CSA, and felt that there was poor knowledge in general health services of specialist services for survivors of CSA. Often women heard about services from other women or by finding pamphlets 'accidentally.'

The participants all expressed dissatisfaction with access to long-term counselling, stating, *'Ultimately this was what made a difference.'* Counselling or psychotherapy needed to be long-term as the women found difficulty in establishing a trusting relationship.

What was useful in services

The most effective services were, *'Services that listened – provided an arena for healing.'* Overwhelmingly, women identified being heard and understood as the most crucial aspect of services. They appreciated therapy that acknowledged survivors as experts in their own healing: *'The role of counselling [is] to enable survivors to find the strength within themselves to heal.'*

Participants identified the need to deal with practical issues before therapeutic work could begin: *'You cannot work in therapy whilst constantly drug affected.'* Some participants suggested that the effect of trauma needed to be understood as a *'disability that affected every aspect of their life.'* Practical assistance included *'help and encouragement to get a regular routine happening in order to deal with the chaos, accommodation support'* and *'dealing with alcohol and drug problems first.'*

Participants stressed the developmental aspect of recovery, indicating that therapy was about facilitating development of 'self' and that it would happen in stages. The women had been deprived of opportunities to learn about relationships: *'I had no idea how to relate to anyone - work colleagues, neighbours – and I had no idea how things operated in the world. I was constantly terrified of being judged, doing the wrong thing.'* Therapy needed to be flexible; they needed to be able to opt in and out, sometimes for short and sometimes for long periods. They also indicated that they needed a beginning and end of therapy. They needed to work on issues and consolidate the process.

Participants emphasised the importance of establishing boundaries in therapy in order to be clear about the purpose of therapy, and to feel safe. Participants also wanted on-going support, *'knowing the service is there if I need it.'*

What was not useful in services

Many of the points made above regarding the helpfulness of therapy could be inverted to indicate those things that were not helpful. However, in addition to these points some specifically unhelpful aspects of services were identified.

The participants described long waiting lists and being told, *'You are not a priority'* as awful. Also unhelpful was being put on hold, answering machines, feeling rushed and not being heard. Often participants came to therapy when they felt 'ready,' but were disheartened to find that they may have to wait for 18 months or more for one-to-one therapy. They did not want to have to *'tell the story repeatedly,'* and found that the *'questioning of the validity of memories by therapists was very distressing.'*

Participants noted the failure of therapists to 'understand' as being unhelpful; but more specifically they noted *'failure by therapists to understand the façade of coping that belies the turmoil beneath,'* as frightening. One participant wondered, *'What did I have to do to make my psychiatrist see that underneath the apparent coping I was a mess?'*

Many participants said that, *'being blamed if services do not work or are not appropriate,'*

was clearly not useful. Cognitive behavioural therapy (CBT) was specifically cited as one therapy where participants felt that they had somehow 'failed' if they did not, for instance, cease self-harming. Also negatively viewed was being told that they were '*not ready yet*,' if the therapeutic model did not work. They found this '*invalidating, like you are not worthy of recovery*.'

Models of therapy

Participants wanted a flexible approach and not a rigid program of therapy. They wanted therapy and counselling to start from where they were functioning; to establish their own goals in therapy; not to dwell on the story of abuse; and to deal with the effects of abuse in the present.

The women indicated that no one specific therapy model was considered the 'fix' or the 'answer.' CBT and Dialectic Behaviour Therapy (DBT), for example, were seen as possibly helpful for some stages of recovery. For some participants, CBT and DBT were helpful in providing skills in managing chaotic thoughts, over-sensitivity to others, and internalised negative messages. However, these skills needed to be learned within the safety of a therapeutic approach that attended to boundaries and trust and created a 'safe space.'

Dependency

Several participants discussed the issue of dependency, described by one as 'dangerous dependency.' They talked of the danger of becoming professional 'victims' unable to move on from support groups, therapy, and a 'sick-role.' However, it was also acknowledged by participants that some women might need prolonged support to be able to maintain a level of functioning.

Self-help groups

Survivor-led self-help groups were described as powerful and supportive, but the notion that survivors were the only ones to help other survivors was criticised. Survivor-led services were described as useful in providing understanding that the person was not alone, and that other people respond to trauma in a similar way. It was strongly emphasised, however, by several participants that therapy groups needed

structure, guidelines and standards provided by professionals, without which there was a danger of re-traumatisation.

Getting on track

Participants spoke of their difficulty in establishing a sense of self and then experiencing further difficulties working to create a life that was satisfying and non-abusive. Educational opportunities were hard to access, and they needed mentoring and goal-directed support.

Some participants had successfully completed tertiary education and had found education a 'safe' area in which they could succeed. However, they found that employment was a difficult hurdle. They needed support and mentoring to negotiate a place in the workforce. Several participants cited exercise as useful in establishing a way of caring for self, and particularly for managing anxiety.

Mental health services

Although not explicitly requested, all participants raised the issue of mental health services. Participants identified that there was not enough training to work with survivors of CSA, and that staff in mental health services frequently did not manage disclosure well. When the participants were seriously unwell, chaotic and self-harming, mental health service delivery was often further traumatising. However, individual staff members, particularly mental health nurses, were identified as, '*a lifeline in all that chaos*.'

Several participants identified community nurses as, '*more understanding than other members of the mental health team, and more likely to work collaboratively*.' These nurses provided ongoing support, therapy, empathy and understanding, and practical assistance in sorting out the chaos. However, participants acknowledged that mental health services were under-resourced and described experiences of being told, '*You are not chronic enough for our service*', and '*We only deal with the seriously mentally ill*.'

Psychiatrists were criticised for a failure to acknowledge the effect of childhood abuse, and their interest in managing symptoms, not in the cause of distress. However, psychiatrists who were also psychotherapists were very warmly appreciated: '*He is the first person who has*

given me hope that I can one day be able to relate to other people, particularly to men.' 'She does not assume that all my problems come from a 'mental illness' – she talks about how what is happening now might be related to what happened in the past.'

Medical issues

The problem of women survivors seeking and obtaining medical attention was raised. It was suggested that advocacy services needed to be provided for women survivors attending medical appointments, particularly those that involved invasive procedures. Despite suffering extensive mutilative damage to the genital area, women indicated that generally this was never referred to, even during gynaecological examinations: *'The physical damage done by CSA is seldom recognised or acknowledged by GPs, gynaecologists, or in fact anyone. There is a failure to ask, even if they identify the damage, if the woman would like to consider reconstructive surgery. There is still huge secrecy around this.'*

Community understanding of CSA

Participants identified that poor understanding in the broader community, of trauma and its sequelae, was unhelpful. Often CSA was related to 'stranger danger,' and not to intra-familial abuse. Participants felt there was a need for early detection and intervention for children in abusive situations, and were highly critical of the inability to detect abuse, and of inaction even when abuse is suspected. They spoke of their experience of teachers and health staff *'turning a blind eye'* and even of suggesting, *'such difficulties made you strong!'*

There was also a failure to acknowledge and consider learning difficulties that may be related to what had happened to the child/adolescent, rather than something innately 'wrong' with the child. Participants described trying to tell of the abuse as children, only to be met with disbelief, and then having to deal with the subsequent overwhelming shame.

Discussion

This study provided a description of the experiences of services for women who have suffered CSA, from the perspective of the women who use the services. The qualitative

nature of the study allowed in-depth discussion of what was important to participants in receiving services. The women who participated had accessed NGO services as well as other health services, and were able to indicate what experiences of services were helpful and unhelpful. There were, however, limitations to the study. Women who had not been able to access services or who did not attend services for other reasons could not be accessed for the study. The small number of participants imposes limitations on the generalisability of the study; however, the number of participants is within expectations for qualitative studies.

The participants in this study had experience of a range of services and clearly identified a range of issues that they strongly felt needed to be voiced. Their tenacity and strength was admirable. Many women had suffered in isolation for years before seeking help, and many had worked hard to overcome enormous obstacles of addiction, depression, anxiety and low self-esteem to be able to make a place in the world. They were appreciative of therapists and services that had treated them with compassion and patience, and were keen to advocate for services for women who had been unable to access such services.

The findings confirm the complexity of the problems experienced by women who have suffered CSA. The problems identified by the women in this study reflect international literature linking CSA with a range of psychological problems, including depression, anxiety, substance abuse, eating and post-traumatic stress disorders (see for instance: Briere & Runtz, 1987; Fergusson et al., 1996). Some women in this study had been diagnosed with personality disorders, displaying characteristic signs related to hypersensitivity, fear of abandonment, disturbances in self-identity, unstable relationships, risky and self-harming behaviours. This picture is consistent with work by Cozolino (2005) who suggested that this presentation when combined with a history of childhood trauma may be a variant of post-traumatic stress disorder.

The participants were quite clear about what was important to them in terms of a therapeutic process. What was important to these women

was being heard and understood, being able to access a safe place for healing, and learning about self and others. They were aware of the need for trust and for clear boundaries. Understanding the effect of trauma on the way they responded to current situations was seen as valuable. They needed services when they had achieved a level of readiness to address emotional issues, and they wanted therapy that had a clear beginning and end, with goals. Interestingly much of what participants stressed as important in therapy reflects current literature and research on what creates change in therapy. Fonagy and Bateman (2006) postulate that the process of change in therapy for traumatised people requires 'thinking about feelings, thoughts and beliefs in the context of attachment' (p.425). The process of attending to attachment allows for the review of previously held patterns of attachment, not only at a conscious level, but at a biological level. Therapy can thus create an arena for reconsidering and reframing relationships and possibilities. The women in this study confirm this from their experience of therapy, and were able to clearly articulate what was important to them. In addition, whilst specific modalities were seen as helpful for some symptoms, the participants emphasised the importance of all models of therapy being conducted within a therapeutic frame that attended to boundaries and trust, the essential elements of attachment processes.

The women had a plethora of socio-economic problems. Some women were or had been in danger of homelessness, had difficulty with parenting, and lived or had lived lives that were chaotic. They described difficulties in employment, education and social relations. Whilst the psychotherapeutic process was important, of equal importance was dealing with practicalities of housing, education, and employment, establishing a routine, and dealing with substance abuse. It was only when these were in some order that the women felt they could move on to work in therapy. This is congruent with Herman (2001) who advocated attending to issues of practicalities, safety and therapeutic alliance before exploratory work begins (p. 172).

The women's experiences of mental health services were mixed. All described mental health services as poor overall in terms of access, the re-traumatising effects of in-patient units, and a failure to manage disclosure of CSA. However, some women did cite specific staff as helpful, supportive, empathic and encouraging. These experiences are consistent with studies on attitude to clients with BPD in mental health services where nurses were found to perceive these clients as manipulative, and admitted to lacking knowledge in how to provide care (Deans & Meocevic, 2006). However, attitude change has been demonstrated with brief training (Krawitz, 2004).

The findings of this study confirm much of the anecdotal evidence and speculation about services for women adult survivors of CSA. Whilst the NGO sector clearly has taken much of the responsibility for providing services to these women, they are funding and resource limited. The participants emphasised that services were inadequate to meet the needs of women survivors of CSA, and confirmed literature from Australia that indicated that there was difficulty in accessing long-term affordable counselling, and a lack of support groups (Keel, Fergus & Heenan, 2005). There is often a window of opportunity to make change that may be beneficial, but that opportunity may be lost due to unavailability of appropriate services. In addition, all participants raised the issue of inadequate responses from health services, including mental health and drug and alcohol services. When clients had multiple problems involving mental illness and drug and alcohol use, they often were not seen as fitting the profile for either service. When clients had diagnoses of BPD, there was very limited access to psychotherapeutic programs within the public sector. Rural and remote areas have very little access to specialist services for women survivors of CSA.

Invasive medical procedures were identified as highly distressing by participants, in accordance with the study by Robohm and Buttenheim (1996) which identified these procedures as 'trigger' events for overwhelming emotions, sensory recall and traumatic memories. In addition, the issue of genital damage and

mutilation was raised by participants with reference to an overwhelming failure of medical practitioners to suggest referral for corrective surgery.

Community knowledge of CSA, how trauma might affect child and adolescent development, and appropriate interventions were seen to be deficient. There was a failure to identify 'difficult' child and adolescent behaviour as a possible indication of abuse.

Conclusion

The cost to the individual, families, communities and health and welfare services of CSA is enormous. The costs spiral exponentially as the difficulties encountered by the women affect all aspects of their lives, frequently impacting on the next generation.

The cost to the community of not providing services is high. Failure to provide effective therapy leads to a continuation of support at a crisis level with no real long-term benefit. The women in this study provided clear indication of what was important to them in terms of a process of recovery, and this accorded with contemporary research.

References

Brewerton, T. (2004). (Ed). *Clinical Handbook of Eating Disorders*. New York: Marcel Dekker.

Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, T. Reid, & C. Jenny (Eds.), *The APSAC Handbook on Child Maltreatment* (2nd edition). Newbury Park, CA: Sage Publications.

Briere, J. & Runtz, M. (1987). Post-sexual abuse trauma: Data and implications for clinical practice. *Journal of Interpersonal Violence*, 2, 367-379.

CASA House (1997). *Sexual Assault Statistics*. Melbourne: The Royal Women's Hospital. Accessed 14 November 2006 at www.rwh.org.au/casa/info.cfm?doc_id=4004

Council of Social Service of New South Wales (NCOSS) (2004). *Better Social Results for NSW. Social and Economic Priorities for a Fair and Sustainable Community: 2005-2006 State Budget*. Sydney: NCOSS.

Cozolino, L.J. (2002). *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain*. New York: Norton.

Cozolino, L.J. (2005). The impact of trauma on the brain. *Psychotherapy in Australia*, 11(3).

Deans, C. & Meocevic, E. (2006). Attitudes of registered psychiatric nurses towards patients diagnosed with borderline personality disorder. *Contemporary Nurse*, 21(1), 43-49.

Fergusson, D.M., Horwood, L.J., & Lynskey, M.T. (1996). Childhood sexual abuse and psychiatric disorders in young adulthood. Part II: Psychiatric outcomes of sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 1365-1374.

Fergusson, D.M. & Mullen, P.E. (1999). *Childhood Sexual Abuse: An Evidence Based Perspective*. Thousand Oaks, CA: Sage.

Fonagy, P. & Bateman, A.W. (2006). Mechanisms of change in mentalization-based treatment of BPD. *Journal of Clinical Psychology*, 62(4), 411-430.

George, L.K., Winfield, I., & Blazer, D.G. (1992). Socio-cultural factors in sexual assault: Comparison of two representative samples of women. *Journal of Social Issues*, 48, 105-125.

Herman, J.L. (2001). *Trauma and Recovery: From Domestic Abuse to Political Terror*. London: Pandora.

Keel, M., Fergus, L. & Heenan, M. (2005). Home truths: a conference in review. *Issues No. 3: Australian Centre for the Study of Sexual Assault*. Melbourne: Australian Institute of Family Studies. http://www.aifs.gov.au/acssa/pubs/issue/acssa_issues3.pdf

Kendall-Tackett, K.A. (2000). Physiological correlates of childhood abuse: Chronic hyperarousal in PTSD, depression, and irritable bowel syndrome. *Child Abuse and Neglect*, 24(6), 799-810.

Krawitz, R. (2004). Borderline personality disorder: Attitudinal change following training. *Australian and New Zealand Journal of Psychiatry*, 38, 554-559.

McLewin, L.A. & Muller, R.T. (2006). Childhood trauma, imaginary companions, and the development of pathological dissociation. *Aggression and Violent Behaviour*, 11, 531-545.

Meares, R. (2005). *The Metaphor of Play* (3rd edition). London: Routledge.

Mullen, P.E., Martin, J.L., Anderson, J.C., Romans, S.E., & Herbison, G.P. (1993). Childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry*, 63, 721-732.

NSW Health (1997). *NSW Health Sexual Assault Services Data Collection, 1997-1998: Initial Contact at Sexual Assault Services*. Accessed 13 November 2006 at www.health.nsw.gov.au/pubs/s/sas/tables.html

O'Brien, L., Henderson, C.M., & Bateman, J. (2006). *Reframing Responses: Improving Service Provision to Women Survivors of Child Sexual Abuse who Experience Mental Health Problems. Report & Recommendations*. Sydney: Mental Health Coordinating Council.

Pearlman, L.A. & Saakvitne, K.W. (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. New York: Norton.

Robohm, J.S. & Bittenheim, M. (1996). The gynaecological care experience of adult survivors of childhood sexual abuse: A preliminary investigation. *Women and Health*, 24, 59-75.

Skodol, A.E., Siever, L.J., Livesley, W.J., Gunderson, J.G., Pfohl, B., & Widiger, T.A. (2002). The

borderline diagnosis II: Biology, genetics, and clinical course. *Biological Psychiatry*, 51, 951-963.

Silverman, A.B., Reinherz, H.Z., & Giaconia, R.M. (1996). The long-term sequelae of child and adolescent abuse: a longitudinal community study. *Child Abuse and Neglect*, 20, 709-723.

Teicher, M.N., Anderson, S.L., Polcari, A., Anderson, C.M., Navalta, C.P., & Kim, D.M. (2003). The neurobiological consequences of early stress and childhood maltreatment. *Neuroscience and Behavioral Reviews*, 27, 33-44.

Watson, S., Chilton, R., Fairchild, H., & Whewell, P. (2006). Association between childhood trauma and dissociation among patients with borderline personality disorder. *Australian and New Zealand Journal of Psychiatry*, 40, 478-481.